Nursing Care Quality Assurance Commission (NCQAC)
Regular Meeting Agenda
September 13, 2013 8:30 AM
Center Point Conference Center
20809 72nd Avenue S. Kent, WA 98032
Commons Area Mt. Rainer Room

Commission Members:	Suellyn Masek, MSN, RN, CNOR, Chair Erica Benson-Hallock**,** MPPA, Public Member, Vice-Chair Linda Batch, LPN Charlotte Foster, BSN, MHA, RN Roger Gantz, MUP, BA, Public Member Lois Hoell, MS, MBA, RN Margaret Kelly, LPN Gene I. Pingle, BSN-BC, CEN, RN Donna L. Poole MSN, ARNP, PMHCNS-BC Diane Sanders, NEA-BC, MN, RN Laurie Soine PhD, ARNP Cass Tang, PMP, Public Member Rhonda Taylor, MSN, RN Susan Woods, PhD, RN, FAAN Laura Yockey, LPN
Assistant Attorney General:	Gail Yu, Assistant Attorney General
Staff:	Paula R. Meyer, MSN, RN, Executive Director Debbie Carlson, MSN, RN, Nursing Practice Advisor Teresa Corrado, LPN, Health Services Consultant Mary Dale, Discipline Manager Michael Hively, Administrative Assistant Karl Hoehn, Staff Attorney Mindy Schaffner, PhD, MSN-CNS, RN, Nursing Education Advisor Anne Schuchmann, MSN, RN, Deputy Executive Director Catherine Woodard, Chief Investigator Martha Worcester, PhD, ARNP, ARNP Advisor

If you have questions regarding the agenda, please call the NCQAC office at 360-236-4713. Items may be taken out of order. If you wish to attend the meeting for a single item, contact our office at the number listed above and request a specific time scheduled for that item.
This meeting is accessible to persons with disabilities. Special aids and services can be made available upon advance request. Advance request for special aids and services must be made no later than September 6, 2013. If you need assistance with special needs and services, please leave a message with that request at 1-800-525-0127 or, if calling from outside Washington State, call (360) 236-4052. If you have limited English language expertise call 360-236-4713 before September 6, 2013. TDD may also be accessed by calling the TDD relay service at 1-800-833-6388. If you need assistance due to a speech disability, Speech to Speech provides human voicers for people with difficulty being understood. The Washington State Speech to Speech toll free access number is 1-877-833-6341.

This meeting will be digitally recorded to assist in the production of accurate minutes. All recordings are public record. The minutes of this meeting will be posted on our website after they have been approved at the November 8, 2013 NCQAC meeting. For a copy of the actual recording, please contact the Public Disclosure Records Center (PDRC) at PDRC@doh.wa.gov .

Smoking is prohibited at this meeting.

I. 8:30 AM Opening – Suellyn Masek, Chair – DISCUSSION/ACTION

II. Call to order

A. Introductions – New NCQAC members and staff
B. Order of the Agenda
C. Correspondence
D. Announcements – October 2 meeting with Dr. Susan Hassmiller

III. 8:40 AM Consent Agenda – DISCUSSION/ACTION

Consent agenda items are considered routine agency matters. The NCQAC approves the consent agenda by a single motion without separate discussion. To discuss a separate item requires a motion to remove the item and then place the item on the regular business agenda.

A. Approval of minutes
   1. NCQAC Business Meeting, July 12, 2013.
   2. Licensing and Discipline sub-committee, March 25, & April 29th, 2013.
   3. Consistent Standards of Practice sub-committee, August 6, 2013.
   4. Continuing Competency sub-committee, July 19, 2013.
   5. Nursing Program Approval Panel (NPAP), May 3, & May 16, 2013.
   6. Nursing Assistant – Nursing Program Approval Panel (NA-NPAP), June 10, 2013.
   7. NCSBN Executive Officer Forum – Licensure Models – July 15-16, Chicago

IV. 8:45 AM – 9:15 AM Chair Report –Suellyn Masek - DISCUSSION/ACTION

A. National Council of State Boards of Nursing's (NCSBN) Annual Meeting, August 14-16, Providence RI – Suellyn Masek, Dr. Susan Woods, Margaret Kelly, Dr. Mindy

Schaffner, Paula Meyer

B. Commission Vice Chair Position Description – revision to give the vice chair the Responsibility for the development and implementation of the HB 1518 report

C. Commission Member Expectations

V. 9:15 AM – 10:00 AM Executive Director Report – Paula Meyer – DISCUSSION/ACTION

A. HB 1518 report – Consultant announcement and timeline

B. Potential to change title from Nursing Care Quality Assurance Commission to Washington State Board of Nursing: analysis of laws and impacts

C. Procedure 04.02 Commission Pay – at the May 2013 NCQAC meeting, the procedure was revised to add pay for preparation for NCQAC meetings. The NCQAC requested a report on the time used to prepare for the May and July meetings.

D. Rules update – Anne Schuchmann, Dr. Mindy Schaffner, Teresa Corrado

E. New member orientation and educational sessions at NCQAC meetings

F. 2013 Fee changes

G. Sub-committee Q&A

H. Uniform Disciplinary Act report

I. Disciplinary Procedures

10:00 AM – 10:15 AM BREAK

VI. 10:15 AM – 11:15 AM Subcommittee Reports – DISCUSSION/ACTION

A. Licensing and Discipline – Margaret Kelly, chair

1. Substance Use and Abuse Team 2 (SUAT2)
2. Practice on an expired license

B. Continuing Competency – Lois Hoell, chair

1. Draft rules WAC 246-840-125 Retired Active Credential hearing scheduled for November 8, 2013.

C. Consistent Standards of Practice – Gene Pingle, chair

1. Advisory Opinion – Camp Nursing
2. Advisory Opinion – Registered Nurse First Assistant
3. Interpretive Statement – Delegation for Administration of Rectal Diazepam (Diastat®) to Unlicensed Assistive Personnel (UAP) for Status Epilepticus
4. Advisory Opinion - Delegation for Administration of Rectal Diazepam (Diastat®) to Unlicensed Assistive Personnel (UAP) for Status Epilepticus

D. Advanced Registered Nurse Practitioner, Donna Poole, chair

VII. 11:30 – 1:00 PM Lunch DISCUSSION/ACTION

Gail Yu, Assistant Attorney General, will provide the NCQAC with training on the role of NCQAC members in response to media requests.

VIII. 1:00PM - OPEN MICROPHONE

Open microphone is for public presentation of issues to the NCQAC. If the public

has issues regarding disciplinary cases, please call 360-236-4713.

IX. 1:15 PM – 2:30 PM Criminal Background Checks – Lindsay Beaver, J.D., NCSBN Legislative Affairs Associate, Nursing Regulation, and Beth Radtke, MS, Associate, NCSBN Nursing Regulation - DISCUSSION/ACTION

Item LI C3 on the 2013- 2015 NCQAC Strategic Plan describes the plan to increase the use of Criminal Background Checks. Ms. Beaver and Ms. Radtke present on models used in other States and their outcomes.
Ms. Meyer and Ms. Woodard give an update on their work on Criminal Background Checks.

2:30 PM – 2:45 PM BREAK

X. 2:45 – 3:00 PM Delegation to a hearings officer for Brief Adjudicative Hearings – Karl Hoehn and Dr. Mindy Schaffner - DISCUSSION/ACTION

Nursing Education Programs undergoing the NCQAC approval process have the right to request a brief adjudicative hearing if there are concerns related to the facts presented to the Nursing Program Approval Panels and their outcomes. Mr. Hoehn and Dr. Schaffner will describe the process and request the NCQAC to delegate to a Hearing Officer for these proceedings.

XI. 3:00 PM – 3:15 PM Public Disclosure of Lists and Labels – Paula Meyer - DISCUSSION/ACTION

Public disclosure laws allow for the NCQAC to recognize educational organizations and professional associations. Once recognized, these entities may receive lists of nurses addresses. The NCQAC will review the list of previously recognized entities and decide if the entity meets the legal definition of educational organization or professional association.

XII. 3:15 PM – 3:30 PM – Meeting Evaluation

3:30 - Closing

Nursing Care Quality Assurance Commission (NCQAC)
Regular Meeting Minutes
Friday, July 12, 2013
Point Plaza East, Room 152/153
310 Israel Road SE
Tumwater WA

Commission Members:	Suellyn Masek, MSN, RN, CNOR, Chair
	Erica Benson-Hallock, MPPA, Public Member, Vice-Chair
	Linda Batch, LPN
	Charlotte Foster, BSN, MHA, RN
	Roger Gantz, MUP, BA, Public Member
	Lois Hoell, MS, MBA, RN
	Margaret Kelly, LPN
	Gene I. Pingle, BSN-BC, CEN, RN
	Donna L. Poole MSN, ARNP, PMHCNS-BC
Absent:	Diane Sanders, NEA-BC, MN, RN
	Laurie Soine, PhD, ARNP
	Cass Tang, PMP, Public Member
	Rhonda Taylor, MSN, RN
Absent:	Susan Woods, PhD, RN, FAAN
	Laura Yockey, LPN

Assistant Attorney General: Gail Yu, Assistant Attorney General

Staff:	Paula R. Meyer, MSN, RN, Executive Director
	Anne Schuchmann, MSN, RN Deputy Executive Director
	Debbie Carlson, MSN, RN, Nursing Practice Advisor
	Teresa Corrado, LPN, Health Services Consultant
	Mary Dale, Discipline Manager
	Karl Hoehn, Staff Attorney
	Shari Kincy, Secretary
	Mindy Schaffner, PhD, MSN-CNS, RN, Nursing Education Advisor
	Catherine Woodard, Chief Investigator
	Martha Worcester, PhD, ARNP, ARNP Advisor

The NCQAC digitally records all meetings to assist in the production of accurate minutes. All recordings are public record. The minutes of this meeting will be posted on our website after approval at the September 13, 2013 NCQAC meeting. For a copy of the actual recording, please contact the Public Disclosure Records Center (PDRC) at PDRC@doh.wa.gov .

I. 8:30 AM Opening – Suellyn Masek, Chair – DISCUSSION/ACTION

II. Call to order

A. Introductions – new commission members and new staff

B. New Officers take their positions – Suellyn Masek, chair; Erica Benson-Hallock, vice chair

C. Order of the Agenda: item added to Executive Director report: location of September and November 2013 and May 2014 meetings

D. Correspondence

E. Announcements – Approximately August 1, the office will move to the first floor, Town Center 1; address remains the same; Medication Assistant Endorsement rules were filed with the Code Revisor's Office on July 7, 2013.

III. Consent Agenda

Consent agenda items are considered routine agency matters. The NCQAC approves the consent agenda by a single motion without separate discussion. To discuss a separate item requires a motion to remove the item and then place the item on the regular business agenda.

A. Approval of minutes

1. NCQAC Business Meeting, May 10, 2013
2. NCQAC Disciplinary Hearing minutes
3. Advanced Registered Nurse Practitioner (ARNP) sub-committee minutes
4. Licensing and Discipline sub-committee
5. Consistent Standards of Practice sub-committee
6. Continuing Competency sub-committee
7. Nursing Program Approval Panel (NPAP)
8. Nursing Assistant – Nursing Program Approval Panel (NA-NPAP)
9. Licensing reports
10. NCSBN IT Conference – Cass Tang, Anne Schuchmann
11. NCSBN Discipline Summit report – Catherine Woodard, Mary Dale, Kathy Anderson
12. NCQAC hours for 2012-2013
13. Western Washington AHEC Industrial Forum – Margaret Kelly
14. NCSBN EO Summit, June 18, 19, Lake Geneva, Wisconsin – Paula Meyer, Suellyn Masek, Lois Hoell
15. Future of Healthcare in Washington State – Sue Woods

MOTION: Motion by Ms. Tang with a second by Ms. Hoell to remove items #1, #4, & #5 for changes. Motion Passed.

MOTION: Motion by Ms. Tang with a second by Ms. Hoell to adopt the consent agenda with edits to items #1, #4, and #5. Motion Passed.

IV. Chair Report –Suellyn Masek

A. HB 1518

1. Delegation to steering committee for actions
   - Ms. Masek requested delegation from the commission to the Steering Committee for work on HB 1518.
   - Ms. Masek requested a change to the position description for the Steering Committee.
2. Report deliverables, timelines
   - Ms. Meyer informed the NCQAC she is searching for a contractor to analyze and evaluate the information gathered in Arizona, work with the steering committee and develop a report for the governor and legislature.
   - Ms. Meyer acknowledged Greg Hammond for his work to find a contractor and complete the process to procure a contractor.
   - Ms. Meyer will have a draft report for the November meeting.

MOTION: Motion by Ms. Taylor with a second by Ms. Hoell to revise the position description to capture HB1518 and delegate the responsibility to act on behalf of the full NCQAC to the Steering Committee. Motion Passed.

B. Institute of Regulatory Excellence draft procedure

MOTION: Motion by Ms. Benson-Hallock with a second by Ms. Hoell to adopt the IRE draft procedure.
Friendly amendment: Friendly amendment by Ms. Kelly for consistency when referring to NCQAC. Motion Passed.

C. Sub-committee and panels: appointment of chair person and members
   - Ms. Masek asked the current sub-committee chairs with the exception of Ms. Taylor if they would like to continue as Chair of their sub-committee. All agreed. Ms. Masek appointed Lois Hoell as the chair of the Continuing Competency sub-committee.

V. Executive Director Report – Paula Meyer

- Ms. Meyer discussed the date, time and locations of the September, November, and May meetings.

Motion: Motion by Ms. Kelly with a second by Mr. Pingle to keep the dates of the September, November, and May meetings the same. Motion Passed.

Motion: Motion by Ms. Benson-Hallock with a second from Ms. Hoell to reserve a location for the September meeting somewhere along the I5 corridor, the November meeting via video conference, and May meeting in Spokane. Motion Passed.

A. Commitment to Ongoing Regulatory Excellence (CORE) report
   - Ms. Meyer discussed the 1103 report presented in November 2013 that compared performance of the North Carolina Board of Nursing and the Arizona State Board of Nursing with the NCQAC performance. Both North

Carolina and Arizona consistently rank as best performers using the CORE data points. Ms. Meyer explained the logic model used to the develop the CORE measures and shared the Washington State results. CORE measures will be used to compare performance in the HB 1518 report.

Motion: Motion by Ms. Hoell with a second by Ms. Kelly to delegate the organization of the report to the Steering Committee as part of HB1518 placing Ms. Benson-Hallock in charge of such organization. Motion Passed.

B. 2013 - 2015 Strategic Plan

- Ms. Meyer acknowledges Oriana Merritt's work for formatting and organizing the draft report.

Motion: Motion by Ms. Tang with a second by Ms. Hoell to adopt 2013-2015 Strategic Plan.
Friendly Amendment: Friendly Amendment by Ms. Tang second by Ms. Foster to remove the specific AAG name in item #3 on page 1 of hard copy. Amendment Passed.
Friendly Amendment: Friendly Amendment by Ms. Poole with a second by Ms. Tang to change a word from "and" to "of" in the consultants section. Motion Passed

C. 2013 – 2015 Budget

- Ms. Meyer discussed the impact legislature's passage of a state budget allotment procedures by legislature, and how the NCQAC was impacted. Kathy Andersen, Anne Schuchmann, and Greg Hammond will work together and use the strategic plan and operating costs to project the 2013-2015 budget.
- Ms. Meyer asked for three Commission members to work with Ms. Schuchmann to provide feedback on the budget. Ms. Tang, Ms. Benson-Hallock and Ms. Hoell volunteered.

VI. Nominations Committee – Cass Tang, Lois Hoell, and Rhonda Taylor

The nominations committee was charged to develop an annual Nursing Commission Award. Applications for the award(s) were submitted. The committee members announced the award winner(s).

- Thomas Bolender, Donna Rogers, and Barbara Elsner were recognized for going above and beyond their daily duties.

VI. 11:30 – 1:00 PM Lunch – Educational Presentation

Interpretive statements, advisory opinions, and declaratory orders – Gail Yu, Debbie Carlson, Dr. Martha Worcester, Gene Pingle

- Ms. Yu presented the difference among interpretive statements, advisory opinions, and declaratory orders.

VII. 1:00PM - OPEN MICROPHONE

The NCQAC reserves time on their agenda for public presentation of issues.

- Dr. Sally Watkins addressed the NCQAC on _____.
- Ms. Benson-Hallock read an email from a nurse in Spokane voicing her

concerns about licensing fees.

VIII. Subcommittee Reports

A. Licensing and Discipline – Margaret Kelly, chair

1. Expired license
    - Ms. Hoell updated the NCQAC on the information she discovered on nurses practicing with expired licenses

Motion: Motion with a second from the sub-committee to adopt the revisions to procedures A06 and A27 to close cases of unlicensed practice for less than 2 years as below threshold. Sanctions standards will apply to cases of unlicensed practices for 2 or more years. Motion Failed.

Motion: Motion by Ms. Benson-Hallock with a second from Ms. Foster to send the expired license procedure back to the sub-committee. Motion Passed.

2. Substance Use and Abuse Team (SUAT2)
    - Mr. Hoehn briefly updated the NCQAC on the work of SUAT2 related to suspension of a nursing license when Washington Health Professional Services (WHPS) participants fail to comply with their contract.

B. Continuing Competency – Rhonda Taylor, chair

1. Retired Active continuing competency requirements
    - Ms. Taylor gave an update on retired active requirement status
    - Ms. Taylor is stepping down as chair of the sub-committee and Ms. Masek appointed Ms. Hoell as the new chair

C. Consistent Standards of Practice – Gene Pingle, chair

- Mr. Pingle introduced the newest Nurse Practice Advisory Group (NPAG) members. An orientation to the NPAG duties is scheduled on July 25, 2013.

D. Advanced Registered Nurse Practitioner, Donna Poole, chair

- Ms. Poole reported that the sub-committee will have a retreat to discuss their strategic plan.

IX. Washington Center for Nursing – Linda Tieman

Ms. Tieman, executive director of the Washington Center for Nursing, presented the deliverables due on June 30, 2013. The 2013 legislature passed and Governor Inslee signed House Bill 1343. This law removed the June 30, 2013 deadline to collect the $5 surcharge on nursing licenses and directs the Department of Health to continue to collect the $5 surcharge on nursing license fees. The $5 surcharge supports the work of the Center. The Department of Health will continue to collect the surcharge and grant this to the Center for Nursing based on the satisfaction of the deliverables.

- Ms. Tieman gave an update on the deliverables for the current contract and informed the NCQAC that she and Ms. Meyer and Ms. Schuchmann are working on the next contract.

IX. House Bill 2366 – Suicide Prevention Education – Alyson R. Kohl, MA

Dr. Elaine Walsh and Dr. Carole Hooven of the University of Washington presented the preliminary findings of the study on suicide prevention education. The legislation, passed in 2012, required a thorough analysis of health professional education curriculum dedicated to the prevention of suicides.

- Dr. Walsh and Dr. Hooven gave a presentation to the NCQAC on their preliminary findings and analysis in support of HB2366 on Suicide Prevention Education.

X. NCSBN business reports

A. NCSBN Annual meeting – Suellyn Masek

1. Delegates, attendees
   - Ms. Meyer, Ms. Masek, Dr. Schaffner and Ms. Kelly will be attending the annual meeting. Ms. Masek, as the NCQAC chair, and Ms. Meyer, as the executive director, serve as the delegates.
2. Resolutions
   - Ms. Masek asked for suggestions from the NCQAC for feedback on the nominations for NCSBN officers. Ms. Benson-Hallock suggested support for Joey Ridenour for Area I director.
3. Dr. Susan Woods will receive the NCSBN Exceptional Contribution Award at the Awards ceremony. Ms. Kelly is a member of the Awards committee.

B. NCSBN Committee reports

1. Leadership Succession Committee – Suellyn Masek
2. Item Review Sub-Committee – Gene Pingle
3. Awards – Margaret Kelly
4. Finance - Lois Hoell
5. APRN – Martha Worcester
   - Ms. Worcester stated that the NCSBN APRN Committee has disbanded.
6. Executive Officer Leadership Council – Paula Meyer

XI. 3:45 PM – Meeting Evaluation

PRO	CON
Lunch with staff	Battery life of microphones
Face to Face	Smaller Packets
Individual microphones	Would like improved New Member Orientation
Everyone had sense of humor	Unable to connect to Internet
Continuing training	Could not get post it notes to work in adobe
Staff Awards	

4:00 PM - Closing

Nursing Care Quality Assurance Commission (NCQAC)
Licensing and Disciplinary Subcommittee
Special Meeting
March 25, 2013
Telephone Conference Call
4:00PM

Sub-Committee Members:	Margaret Kelly, Chair; Cass Tang; Lois Hoell
DOH Staff /Guest:	Mary Dale, Teresa Corrado, Miranda Bayne, Catherine Woodard, Margaret Holm; Karl Hoehn
Call to order	Digital recording announcement

Roll call

1. **February Minutes - Margaret**
   DECISION: minutes from the 2/25/13 meeting were approved for the May NCQAC meeting.

2. **Practice on an Expired License – Lois**
   DISCUSSION: Lois presented the recommendation that a Notice of Correction (NOC) be issued for first time practice on an expired license, if the practice does not go beyond the second renewal period. There was discussion of whether a NOC should be issued, or no action taken. Suggestions were made to include this issue in the next newsletter, and for the Nurse Consultants to add the topic to their presentations.
   DECISION: Mary will make the changes to the Sanction Standards procedure (A27) and send to the subcommittee for approval. Mary will add this item to the May 10 NCQAC meeting.

3. **Performance Measures - Margaret**
   DISCUSSION: Margaret reviewed the performance measures for quarter 2, fiscal year 2013. Nursing statistics continue to improve.

4. **Licensing Goals for the Commission Strategic Plan – Teresa**
   DISCUSSION: Teresa presented the goals she submitted for Licensing. They are amending the international rules, adding ARNPs into NURSYS, and creating a satisfaction survey.

5. **Drug Testing for Nurses – Cass**
   DISCUSSION: A draft document has been developed outlining information researched by the task group. At the last commission meeting, the topic was briefly addressed. The AAG advisor cautioned Cass regarding potential litigation. Paula said she may ask for a formal AG opinion. It was suggested the document be sent to National Council, and we work with them.
   DECISION: No action will be taken at this time. Mary will take the document to Paula for review, and ask her to attend the April L&D meeting.

6. **NCQAC Web Page (10) - Mary**
   Paula had asked for subcommittee requests for long and short term changes in the web page.
   DISCUSSION:
   Short term:
   Update links so they work

Add a phone directory
Long term:
A secure website for commission members
One link from DOH to NCQAC
Interpretive statements
NCQAC meetings
Subcommittee information

Cass said that National Council had a good example, but we couldn't use it. She believes we are looking at a whole new website versus updating the old one.
DECISION: Margaret Holm will ask Debbie Carlson about her data on websites and will include Deanne, the new Administrative Assistant who is assigned to the web.
Mary will take this information to the next Manager Meeting, and ask for clarification. This will be added to the next L&D agenda with more time.

7. **Nurse Consultant Update (10) – Margaret Holm**
   Margaret gave her monthly report. The nurse consultants are doing more outreach regarding workforce diversity.

8. **Investigation Update (10) – Catherine**
   Catherine gave her monthly report. Investigation statistics continue to improve.

9. **Work Plan (5) - Margaret**
   Updates were made to the work plan.

Adjournment **5:36 PM**

Nursing Care Quality Assurance Commission (NCQAC)
Licensing and Disciplinary Subcommittee
Special Meeting
April 29, 2013
Telephone Conference Call
4:00PM

Sub-Committee Members:	Margaret Kelly, Chair; Cass Tang; Lois Hoell (excused)
DOH Staff /Guest:	Mary Dale, Teresa Corrado, Miranda Bayne, Catherine Woodard, Margaret Holm (excused)
Call to order	Digital recording announcement

Roll call

1. **March Minutes - Margaret**
   The March 25, 2013 minutes were approved to go to the Nursing Commission for final approval.

2. **Practice on an Expired License –Margaret**
   The procedure changes to be presented at the May NCQAC meeting were reviewed. Practice for less than 2 years will be closed as below threshold, and practice for 2 or more years will be subject to discipline according to the Sanction Standards. Changes are made to two procedures, A06 and A27.

3. **Regulatory Action Pathway - Mary**
   National Council asked the commission to pilot a 6 month test of the "Regulatory Action Pathway" tool on standard of practice cases. The commission agreed to the pilot at the March 2013 commission meeting. Concern was voiced from the Attorney General Office for using the tool on open cases. A meeting was held with AAG Cassandra Buyserie, Margaret Kelly, Catherine Woodard, Mary Dale, and Kathleen Russell of National Council. It was decided to use the tool on recently closed cases to avoid any concern of unfairness. Ten cases will be assessed and the data will be sent to National Council.

4. **Marijuana/Safe to Practice Policy – Margaret**
   A suggestion came from CMT to take the marijuana issue to the full commission to request a more in-depth review.
   DECISION: This will go to the May NCQAC meeting to discuss using the Safe to Practice policy for these cases. There will be discussion regarding an in-depth review at a higher level.

5. **Drug Testing for Nurses – Cass**
   Paula Meyer asked for research into the authorization for airline pilots and ferry pilots for drug testing. Cass researched the topic and provided a summary along with FAA regulations and explanations. She presented the information to the subcommittee.
   DECISION: Cass will resend the memo. Mary will provide this information to Paula for review.

6. **NCQAC Web Page - Mary**

The subcommittee may request changes to the web page, either for short or long term changes. Suggestions included using the National Council plan for their website, ensuring that documents on the web are not outdated, and use of documents that can be filled in online. They reviewed an outline of suggested web changes from staff, and felt it covered everything.

7. **Nurse Consultant Update – Margaret Holm excused**
   The NCI monthly report was reviewed. Workplace diversity was added to the work plan at the last meeting. This is addressed in the report, and Margaret will be reminded to contact Cass if she needs any assistance.

8. **Investigation Update – Catherine**
   Catherine provided the status documents showing investigation progress during the month of March. She discussed upcoming changes in staff.

9. **Performance Measures - Margaret**
   Margaret reviewed the performance measures for Quarter 3 FY2013. She pointed out that measure 2.3 Case Disposition is the best it has ever been. Measure 2.4 Investigations is at 33%, which is the best it has been. The charts show the number of investigations over timelines has steadily decreased over the last few years. The measures will be on the May NCQAC agenda.

10. **NCSBN Discipline Case Management Conference**
    Catherine and Mary will present on "Non-therapeutic prescribing of controlled substances". They were asked to include the power point presentation at the next subcommittee meeting.

11. **Meeting dates – Margaret**
    DECISIONS: The May 27 subcommittee will be cancelled. Meetings will permanently remain at 4:00 p.m. on the last Monday of the month.

12. **Work Plan - Margaret**
    The work plan was reviewed and changes were made.

Adjournment 5:07 p.m.

Consistent Standards of Practice Minutes
August 6, 2013 12:00 PM to 1:00 PM
Nursing Care Quality Assurance Commission (NCQAC)
111 Israel Rd SE, Town Center 2, Room 314
Tumwater, Washington 98501

Committee Members: Gene Pingle RN, BSN-BC, CEN, Chair

Absent: Laura Yockey LPN
Roger Gantz BA, MUP
Charlotte Foster RN, BSN, MHA

Staff: Debbie Carlson MSN, RN
Oriana Merritt, Administrative Assistant

This is a meeting of the Consistent Standards of Practice subcommittee. This meeting is being digitally recorded to assist in the production of accurate minutes. All recordings are public record. The minutes of this meeting will be posted on our website when approved by the full commission. For a copy of the recording, please contact the Public Disclosure Records Center (PDRC) at PDRC@doh.wa.gov .

Subcommittees do not have decision making authority. Recommendations from this subcommittee may be presented at the next scheduled Nursing Commission meeting. Only the NCQAC has authority to take action.

1. **12:00 PM Opening – Gene Pingle**
    a. Call to order & roll call
    b. Introduction
    - Public attendees included Katie Johnson, OSPI and Doug Nelson, Public School Employees

2. **Review of minutes**

3. **Interpretive Statement and Advisory Opinion Draft – Delegation for Administration of Rectal Diazepam (Diastat®) to Unlicensed School Staff for Status Epilepticus**

4. **Advisory Opinion Draft – Camp Nursing**
    - Approved by Gene, advised to submit to NCQAC

5. **Advisory Opinion Draft – Registered Nurse First Assistant**
    - Approved by Gene, advised to submit to NCQAC.

6. **Nurse Practice Advisory Group (NPAG) Updates and Assignments**
    - Delegation is suggested as another topic for NPAG assignment by public attendee Katie Johnson, OSPI
    - Standing Orders is suggested to be added to School Settings Issues by public attendee Katie Johnson, OSPI, to be discussed with NPAG.

7. **Next meeting is scheduled for September 3, 2013 from 12:00 PM – 1:00 PM**

Nursing Care Quality Assurance Commission (NCQAC)
Continuing Competency Subcommittee minutes
July 19, 2013
111 Israel Rd SE, Room 236
Tumwater, WA

Commission Members:	Lois Hoell, MS, MBA, RN, Chair Rhonda Taylor MSN, RN, Linda Batch, LPN Erica Benson-Hallock, MPPA, Public Member
DOH Staff:	Teresa Corrado, LPN, Licensing Manager Linda Patterson, Nurse Consultant Thomas Bolender, Licensing Representative Renee Fullerton, Community Health Systems
Public Attendees:	Karen Greenwalt, RN, Parish Nurse

1. **9:30 AM Opening — Teresa Corrado, DOH Staff**
   - Called to order at 9:35

2. **Discussion/Action of the 96 hour practice requirement for Retired/Active status.**

   - Determine whether or not to keep the practice hour requirement for Retired/Active status at 96 hours every 3 years.

     Discussion: There was concern that nurses who could not meet the requirement would not be able to perform in the event of a disaster. There was also concern that Parish nurses and nurses who volunteer may not be able to meet the requirement. There was a question as to how any number of hours could necessarily guarantee a nurse was more competent than any other. When asked about the research behind the 96 hour determination, the answer was that no research had been done. The number of hours was based on a military model and other countries requirements.

     The public attendee voiced her concerns about the number of hours required. She is a Parish nurse who feels she'll have no problem achieving the requirements but she doesn't feel the number is justifiable. She brought documentation that no other states have such a requirement.

     It was brought up that the rules could possibly be reopened in the future if there was too big a threat of losing good nurses who wouldn't be able to meet the requirement. There was talk of researching the effect after 2014.

     Action: A decision was made to keep the 96 practice hour requirement every 3 years with the possibility of reopening the rules in the future.

3. **Adjourned** – 10:11AM

Nursing Care Quality Assurance Commission (NCQAC)
Nursing Program Approval Panel (NPAP)
PANEL B Agenda
May 3, 2013

Commission Members:	Rhonda Taylor, MSN, RN Chair
Pro Tem:	Karen Heys, MN, RN Laurie Soine, PhD, ARNP Catherine Van Son, PhD, RN
DOH Staff:	Mindy Schaffner, Nursing Education Advisor Carol Knutzen, Nursing Education Assistant Tim Talkington, Staff Attorney

10:00 AM Opening — Rhonda Taylor, Chair

- Call to order
- Review of Minutes from February 21, 2013 NPAP-B meeting

1. **Bellevue Community: Request for Initial Approval of RNB Program**

   Discussion: The nursing program would like approval to establish an ADN to BSN program.

   Decision: Defer action on initial approval with conditions. The program must hire a qualified nurse administrator prior to beginning the program. The panel requests a follow up report on staffing for the ADN and BSN programs. Information to include in the report includes the course number, title of course, credits, number of students and corresponding faculty. The report is due September 15, 2013.

2. **Liberty University: Request to Approve of Clinical Placements for RNB and MSN Administrator Programs**

   Discussion: The panel discussed the program's request for approval of clinical placements for RNB and MSN Administrator programs.

   Decision: The panel denied the RN to BSN program for lack of practice requirements for baccalaureate education [WAC 246-840-575(3)(b)] and the leadership practice component was not addressed WAC 246-840-575(3)(d).

   The panel approved of practice placements for the MSN Administrator Program, pending the Washington State Board of Technical and Community College approval.

3. **Lower Columbia College:**

   Discussion: The panel discussed the program's requests for approval of the Special Project in Nursing Education (SPINE) pilot project and increase in student numbers.

   Decision: The panel approved the request to admit ten (10) additional students to NURS 101 in the fall of 2013. The panel approved of the requests and asked for a copy of the pilot program report in fall 2014.

4. **Whatcom Community College:**

Discussion: The panel discussed the program's request for approval of curricular change. The program would like to implement a concept-based curriculum with clinical redesign.

Decision: The panel approved the requests and asked for refinement of the program outcomes. The program also is required to update the systematic evaluation to adequately evaluate these changes.

5. **Wenatchee Valley College:**

Discussion: The panel discussed the program's request for curricular and program changes. The changes were made in response to the February 2010 NLNAC visit.

Decision: The panel approved of the changes.

6. **Columbia Gorge Community College:**

Discussion: The panel discussed the program's request for clinical site placements in the State of Washington.

Decision: The panel approved the following clinical sites: Skyline Hospital in White Salmon, Klickitat Valley Heath Center in Goldendale, and Klickitat County Health Department. Students may be assigned a clinical experience in Washington during any of the six terms of the Program (NURS 110, NURS 111, NURS 112, NURS 210, NUR 211, and NUR 212).

7. **Carrington College:**

Discussion: The panel reviewed the program's request to send students to various clinical sites that the program is already using.

Decision: The panel approved the requests, pending receipt of confirmation on faculty qualifications. The program also needs to develop a policy on accountability and managing clinical experiences and clinical supervision of students. The following sites were approved for clinical placements, pending receipt of information.

- Canterbury Gardens, Longview WA
- Columbia View Care, Cathlamet, WA
- Community Home Care and Hospice, Longview, WA
- Cowlitz Family Health Center, Longview, Woodland, Kelso, Cathlamet, Oceanpark, WA
- DAVITA, Vancouver, WA
- Discovery Nursing and Rehab, Vancouver, WA
- Children & Family Services, Vancouver, WA
- Evergreen Americana & Rehab, Longview, WA
- Evergreen Frontier Health & Rehab, Longview, WA
- Fort Vancouver Convalescent Center, Vancouver, WA
- Highland Terrace Nursing Center/Prestige, Camas, WA
- Kaiser @ Cascade Park, Vancouver, WA

- Kaiser @ Longview, Longview, WA
- Kaiser @ Orchards, Vancouver, WA
- Kaiser @ Salmon Cree, Vancouver, WA
- Kindred Transitional care of Beaconhill, Longview, WA
- Kindred Transitional Care 7 Rehab, Vancouver, WA
- Lifecare Center @ Cascade park, Vancouver, WA
- Manor Care Health Services @ Salmon Creek, Vancouver, WA
- NW Gynecology Associates, Inc, Vancouver, WA
- Pacific Specialty & Rehab Care, Vancouver, WA
- Peacehealth/Washington Medical Center, Vancouver, WA
- Peacehealth @ Behavioral Health, Longview, WA
- Peacehealth @ Diabetes/Weight Mgmt, Vancouver, WA
- Peacehealth @ Urgent Care, Vancouver, WA
- Peacehealth @ Vancouver Family Planning Clinic, Vancouver, WA
- Peacehealth @ Wound Care Clinic, Vancouver, WA
- The Hampton & Ashley Inn, Vancouver, WA
- The Vancouver Clinics, Vancouver, WA
- US Veterans Affairs, Vancouver Home Health Dept., Vancouver, WA
- Woodland Care Center, Woodland, WA

8. **University of Portland:**

Discussion: The panel reviewed the nursing program's request for clinical site placement for students in Washington State for the BSN, MSN and DNP graduate programs (clinical nurse leaders, nurse educator) programs. The school already uses these sites and has affiliation agreements.

Decision: The panel approved the following sites for BSN student placements

- PeaceHealth Southwest Medical Center, Vancouver
- Legacy Salmon Creek Medical Center, Vancouver
- University of Washington Medical Center, Seattle
- Seattle Children's Hospital
- Harborview Medical Center, Seattle
- Virginia Mason Medical Center, Seattle
- Franciscan Health System, Tacoma
- Multicare Health System, Tacoma
- Kaiser Permanente Washington
- Providence Health & Services Washington
- St. Clare Medical Center, Lakewood
- New Heights Clinic, Vancouver
- Share, Vancouver
- Vancouver Housing Authority
- Washington State School for the Blind

The panel also approved of clinical site placements for the Master of Science (MSN) - Clinical Nurse Leader, MSN-Nurse Educator Program, and DNP program. The program will report the clinical sites at the time of obtaining affiliation agreements.

9. **The panel deferred the review of reconsideration of the non-traditional program -- Excelsior**

10. **Green River – Request approval of LPN to RN program**

Discussion: The panel reviewed the school's request to approve of the Feasibility Study to develop a LPN-RN program.

Decision: The panel did not accept the Feasibility Study and denied beginning the program development phase of the program approval process.

Adjournment: 12:20 PM

Nursing Care Quality Assurance Commission (NCQAC)
Nursing Program Approval Panel (NPAP)
PANEL A
May 16, 2013
10:00am – 12:00pm
Minutes

Commission Members:	Susan Woods, Chair
	Lois Hoell
Pro Tem:	Carl Christensen
	Georgia Pierce
DOH Staff:	Mindy Schaffner, Nursing Education Advisor
	Carole Knutzen, Education Assistant
	Tim Talkington, Staff Attorney
	Marlee O'Neill

10:15 AM Opening — Susan Woods, Chair

The meeting was called to order at 10:15 am. The minutes from March 21, 2013 were reviewed and approved with changes.

- **Seattle Pacific University**
  - **Discussion:** The program requests to increase the number of nursing students by 14 students per academic year until 2014-2015. The program currently has 100 students and would like to increase to 114 students in 2013-2014 and to 128 students in 2014-2015. A letter received from the clinical consortium identified that the school would not be displacing other nursing students this next academic year.
  - **Decision:** The panel approved the request and requested a report due May 2014 regarding clinical placements for the 2014-2015 academic year.
- **St. Martins University**
  - **Discussion:** The university requests approval of its RNB program.
  - **Decision:** The panel decided to provide initial approval of the RNB program. The panel appreciated the academic presentation of the program in terms of curriculum, credits and courses preparing future baccalaureate nurses. The panel was concerned that the program relied heavily on classroom teaching and program development by the program director with limited planning for hiring and retaining additional faculty for program development. The budget identified an increase of one faculty member in 2013-2014 and no further increases. The panel requested more information on the plan for hiring faculty and criteria for

determining the need for additional faculty. The panel also requested more information regarding the program director's role in terms of participation in university governance and committees. The panel would like to know the roles the program director has related to nursing program budget preparation and in the evaluation of nursing faculty [WAC 246-840- 555(3)&(7)].

The panel noted that the systematic plan for evaluation did not include outcome measurements. WAC 246-480-548 requires that the program have a systematic plan for ongoing evaluation that is based on program outcomes and input of faculty, students and consumers which includes continuous improvement. The panel would like to know the outcome measurements and how the evaluation plan will be used for program improvement and on-going continuous quality improvement.

The panel also noted that on page 10 of the proposal, it is stated that faculty must have an unencumbered RN license at the time of hire. WAC 246-840-570(4) requires that faculty members must have an unrestricted license at all times while serving as faculty.

The panel requested that a follow-up report addressing the requests for more information be submitted by July 1, 2013.

- **Western Washington University**
    - **Discussion:** The University requested approval of an RNB program.
    - **Decision:** The panel decided to provide initial approval for the RNB program. The panel requested a report by July 1, 2013 on the following:
        - WAC 246-840- 555(3)&(7) identifies the requirement for the program to be organized so that the nurse administrator has clearly defined institutional authority and administrative responsibility. The panel would like to know the roles the program director has related to nursing program budget preparation and in the evaluation of nursing faculty. What is the university's expectation related to the nurse administrator's role to serve on university committees?
        - WAC 246-480-548 requires that the program have a systematic plan for ongoing evaluation that is based on program outcomes and input of faculty, students and consumers which includes continuous improvement. The panel would like to know the outcome measurements and how the evaluation plan will be used for program improvement and on-going continuous quality improvement.
        - WAC 246-480-575 (3) identifies clinical/practice experiences required for baccalaureate education. Clarification on the number and nature of the clinical/practice hours was requested.
        - The panel requested a copy of the student grievance procedure identified on page 26 of the proposal.

- **University of Pittsburg School of Nursing**

    - **Discussion:** The panel discussed the university's request for approval of clinical site placements for the nurse anesthesia program to use the University of Washington Medical Center for clinical site placements. The school has been using this clinical site for a number of years with usually one student per semester placed at the site. They have an adjunct faculty member licensed as an ARNP in Washington to provide clinical supervision.

    - **Decision:** The panel approved of the request to use the University of Washington Medical Center for clinical site placements of nurse anesthetist students.

- **American Public University System**

    - **Discussion:** The panel discussed the university's request for approval of clinical site placements for an on-line RNB program.

    - **Decision:** The panel denied American Public University's request for the RNB program. The reasons for the denial included:
        - There were no clinical sites identified, as students complete some experiences in their work environment,
        - There were no faculty members identified to oversee the student practice experiences,
        - Clinical experiences were identified as indirect experiences with no direct practice experience, and
        - The program proposal did not include written policies on clinical learning experiences.

- **Kaplan University:**
    - **Discussion:** The panel discussed the university's request for approval of clinical site placements for authorization of the online post-licensure RN-BSN degree program, the online post-licensure MSN degree program and the online post-MSN certificate programs. The MSN degree and post-MSN certificates offer five specializations:
        - MSN – Nurse Administrator
        - MSN – Nurse Educator
        - MSN – Nurse Informatics
        - MSN – Adult-Gerontology Nurse Practitioner
        - MSN – Family Nurse Practitioner

    - **Decision:** The panel denied the request as the program did not identify the clinical sites or number of anticipated students. The program also did not acknowledge assigned faculty for the student practicum. The Nursing

Commission makes decisions on program approvals based on size of program, clinical site availability, and impact on existing programs. Since none of these were identified in the application, the panel was not able to approve of the program for clinical/practice site placements.

- **University of Cincinnati**

  - **Discussion:** The panel reviewed the university's request for approval of Clinical Site Placements for Adult-Gero Primary Care Nurse Practitioner, Family Nurse Practitioner, Adult-Gero Clinical Nurse Specialist, Nurse Midwifery, Psychiatric Nurse Practitioner, and Women's Health Nurse Practitioner.

  - **Decision**: The panel approved the request for the presented students (10 now, 16 and then 14 students) for this upcoming academic year pending that there is a faculty member who is licensed in Washington State. The program must follow the procedure for conferencing with the student and preceptor at least three times per semester. The university needs to be aware of the requirement to not use professionals with any disciplinary action on his or her professional license as this is not allowed by law.

- **University of Northern Colorado**

  - **Discussion:** The panel reviewed the university's request for approval of clinical site placements for senior baccalaureate nursing students in their final capstone practicum.

  - **Decision:** The panel approved the request. The preceptors must be approved in advance; preceptor swapping is not allowed. The program must ensure that the faculty member is licensed in Washington State.

The meeting adjourned at 12: 19 pm.

Nursing Care Quality Assurance Commission (NCQAC)
Nursing Assistant Program Approval Panel (NAPAP)

Minutes

June 10, 2013

Panel Members:	Margaret Kelly, Chair
	Rhonda Taylor
	Roger Gantz (Absent)
	Jackie Rowe
DOH Staff:	Mindy Schaffner, Nursing Education Advisor
	Carole Knutzen, Nursing Education Assistant
	Tim Talkington, Staff Attorney
	Marlee O'Neill, Staff Attorney

1. **10:00 AM Opening — Margaret Kelly, Chair**
   a. Call to Order at 10:01 am
   b. Review of April 8, 2013 Minutes -- Approved with minor changes
   c. Review of May 13, 2013 Minutes -- Approved with minor changes
   d. Review of May 24, 2013 Minutes -- Approve with minor changes

2. **Complaint:**
   a. Tacoma Community College:
      i. Discussion: The panel discussed a complaint related to resident care. Decision: The panel opened for investigation.

3. **Program Review:**
   a. New Chapters in Healthcare Education:
      i. Discussion: The panel reviewed the application for approval of a new program. In addition to the traditional NA curriculum, the program would like to teach students skills to work in acute care and home care. This would include clinical experience in a hospital.
      ii. Decision: The panel deferred action. The panel expressed concern over fact that the program only has a clinical affiliation agreement with a facility that is not a skilled nursing facility. The panel requested information on the length of the CPR and HIV training. The panel also requested information on the instructional staff and the curriculum that they would be teaching.

4. **Instructor Review:**
   a. Evergreen Nursing School:
      i. Discussion: The panel discussed an instructor application which identified that the proposed instructor had actions on his CNA certification.
      ii. Decision: The panel approved the instructor to teach at Evergreen Nursing School.
   b. Sound Vocational Institute:
      i. Discussion: The panel discussed an instructor application which identified the proposed instructor had previous action on her nursing license.
      ii. Decision: The panel approved the individual to be an instructor at Sound Vocational Institute.

5. Plans of Correction for Low Pass Rates

a. Bates Technical College
   i. Decision: The panel approved the plan of correction.
b. Cascade Job Corps
   i. Decision: The panel rejected the plan of correction. The panel requested more information on the program's classroom testing criteria.
c. Clark Community College
   i. Decision: The panel rejected the plan of correction. The panel requested more information classroom and skills testing in the program.
d. Crestwood Convalescent Center
   i. Decision: The panel accepted the plan of correction.
e. Edmonds Wood way High Schools
   i. Decision: The panel rejected the plan of correction. The panel requested information on the specific action plans to help students reduce test anxiety. The panel also requested that the program link actions and contributing factors to test results.
f. Everett Community College
   i. Decision: The panel approved the plan of correction.
g. Forks Community Hospital
   i. Decision: The panel rejected the plan of correction. The panel requested more information about the proposed tutoring program. The panel also would like to know if the program has considered working with another NA program in the area to develop a test site. The panel asked the program to look objectively at the data, make an evaluation and implement changes.
h. Health Care Training Center
   i. Decision: The panel approved the plan of correction.
i. Kelso School District
   i. Decision: The panel rejected the plan of correction. The panel requested more information on the mock testing and clarification on where this will take place. The panel was unclear about what parts of the plan of correction would be adopted into the curriculum.
j. NAC Training Program
   i. Decision: The panel accepted the plan of correction. The panel also recommended that the program consider onsite testing.
k. North Seattle Community College
   i. Decision: The panel approved the plan of correction and asked the program to consider raising the test score from 227 to 230 if the program finds that students with a score lower than 230 fail to pass the licensure test.
l. Seattle Central Community College
   i. Decision: The panel rejected the plan of correction. The panel asked for more information about who will be working with the students in the lab and what that person's role will be. The panel expressed concern over the textbook used for classroom teaching.
m. Willow Springs
   i. Decision: The panel approved the plan of correction.

6. Other

a. The August 12, 2013 meeting conflicts with a NCSBN meeting so we may need to reschedule.

Meeting adjourned at 11:30 am

NCSBN
National Council of State Boards of Nursing

111 E. Wacker Drive, Suite 2900
Chicago, IL 60601-4277

312.525.3600
www.ncsbn.org

Executive Officer Forum
Licensure Models

July 15-16, 2013
Chicago, Illinois

Background

At the 2013 NCSBN midyear meeting, the executive officers (EOs) requested a meeting to discuss the future of licensure models. Two major licensure models currently exist in the U.S. for nursing: a single state model and the mutual recognition model implemented through the Nurse Licensure Compact. Recently, interest increased in a national model of licensure related to improving access to care through telehealth. The growing number of insured through the Affordable Care Act and the aging population drives this interest. Members of Congress and stakeholders such as the telecommunications industry propose legislation on alternative national licensure models. This meeting was convened and a facilitator was engaged by NCSBN for the purpose of framing the issues related to nursing licensure and achieving resolution to the differences in nursing licensure regulation.

Facilitator

Leonard J. Marcus, Ph.D., is the Director of the Program for Health Care Negotiation and Conflict Resolution at the Harvard School of Public Health and Co-Director of the National Preparedness Leadership Initiative. Dr. Marcus pioneered development of the *Walk in the Woods*, a negotiation and conflict resolution exercise. He is experienced in high-level national negotiations.

Framework and Process

Prior to the meeting, Dr. Marcus spoke with eight EOs, both compact and non-compact states, to discuss their perspectives regarding the licensure models so he was introduced to the issues and past conversations regarding the models.

At the meeting, Dr. Marcus began by presenting an introduction to meta-leadership. He discussed a "predictable crisis" or predictable surprise." The premise is that most crises are predictable because usually some people have certain information, and others have different information; if the information and people had come together with all of the information the crisis could have anticipated.

He spoke about leaders integrating different points of view and beliefs. He provided the "cone in the cube" example noting that those who look into the cube from one angle see the triangle of the cone within the cube, and those who look into the cube from a different angle, see the circle of the cone within the cube. We need to come together to find the cone.

He provided models that guided us through the discussions. First, through arm wrestling he illustrated how to achieve a win-win negotiation. Secondly, he spoke about three "levels" of the brain, and participants used the explanation about the design of the brain to frame the conversation. For example, the basement is the lowest level of the brain and when we are there, we freeze, fight, or flight. We need to realize we are there and then re-set our brains to get to the middle of the brain where our "toolbox" is located. The highest level of the brain is the laboratory, for learning and complex thinking.

Dr. Marcus explained the Walk in the Woods (The Walk) that we used for the remainder of the meeting. The Walk is a problem solving method that examines stakeholders' perceived issues and concerns and assists in finding a resolution for complex problems. There are four steps to The Walk that encourage transition from one step to the next:

- *Self-interests*: Participants state their interests and what they hope to gain or achieve.
- *Enlarged interests*: Participants, having heard the interests of others, list what they view as points of agreement among these interests.
- *Enlightened interests*: Participants craft new ideas and possibilities that prior to the discussion they would have been unlikely to contemplate.
- *Aligned interests*: Participants finalize ideas regarding the issue under discussion.

Outcome of The Walk

During the third step, enlightened interests, the group identified the numerous ideas and identified the following ideas to pursue (not in any particular order):

- Centralized registry/clearing house for nursing credentials to be housed at NCSBN in order to expedite licensure.
- "Diamond" (or national) status for nurses who met all states' requirements
- Telehealth permits
- Update compact requirements
- Tandem licensure
- Revenue sharing between NCSBN and Member Boards
- National school accreditation
- National standards
- Staff hired by NCSBN with regulatory experience

After discussion and exploration of the details of the above "enlightened" interests, we moved to discuss "aligned" interests and there was a vote as follows:

- Look at telehealth issue and other more specified issues – 8
- Explore "diamond"/national status – 2
- Develop a borderless model and a new package – 19

EOs clearly stated a desire to lead in creating and implementing solutions. There was a consensus among the EOs that (1) borderless nursing practice is important; (2) state based nursing licensure is preferred and believed to be the best model for public protection; (3) practice occurs where the patient is located; and (4) NCSBN should remain a united organization.

Next Steps

A large number of EOs were not present for the Forum, and the group agreed it was important to have all EOs involved. The group noted that Board Presidents should be informed. President Myra Broadway will meet with state Board Presidents at the Annual Meeting to inform them about the discussion, what was accomplished, and next steps.

Participating EOs will be asked to contact and provide a summary of the meeting to those EOs who were not able to attend. A summary on the event will be provided, and the meetings and discussion will be on the agenda for the EO Leadership Council at the Annual Meeting.

The group stated that to move forward it would be important to continue working with Dr. Marcus. Dr. Marcus agreed to continue working with the group with plans to meet November 18-19, 2013.

It was a unique and invigorating experience for those of us able to attend and participate. Please let me know if you have any questions and/or comments.

Sincerely,

Myra Broadway, JD, MS, RN
President, NCSBN

2013 NCSBN Annual Meeting – President's Networking Session
August 15, 2013 Providence, Rhode Island
Attended by NCQA commission member: Margaret E Kelly LPN

PURPOSE: NCSBN President update report and opportunity to discuss challenging situations and networking for Board of Nursing (Commissions) Chairs / Presidents.

OUTCOMES:

- Review of Midyear meeting minutes (posted on NCSBN Member Only Website).
- Report on NCSBN's Executive Officer July 2013 Forum- Facilitated by: Leonard J Marcus, PhD using; *Walk in the Woods* a negotiation and conflict resolution exercise for processing both perspectives on the nurse compact and non- compact licensure models. Major issues discussed; state based nursing licensure is preferred, need for borderless nursing practice, clarity of where nursing practice occurs (i.e.: telehealth - where the patient is or nurse?), need for background checks in all states and goal for NCSBN to remain a united organization. Another facilitated session is planned for November with a goal for resolution of nursing compact regulation differences.
- Discussion of the ANA Licensure Jurisdiction Proposal. There are implications on regulations. ANA's mission is to protection of the nurse and NCSBN's mission for public protection. NCSBN's legal counsel has drafted a correction and will submit to the board of directors for review, prior to submission to ANA.
- Follow up discussion on a general session comment; "*The Federal government does not view nursing as a profession"*… It was stated this related to reimbursement rates, some RN's are rates are the same as a high school graduate. (More discussion on need to show the value of the nursing profession).
- Some challenging issues other Boards of Nursing facing –
    - Some boards are having issues getting enough members, especially LPN's.
    - Other boards having issue with needing to cancel meetings awaiting Governor's appointments. There was no quorum.
    - One state reported 34% of NCLEX applications are falsified. Result, these are reviewed by investigators for accuracy.
    - One board reported a person was denied to take the NCLEX because of a failed background check. This person was denied by 3 states however, the process was redundant for 2 states. Discussion on the need for background checks and a communication system to alert other states.
    - Nursing background checks need to be approved by legislators. (All but 15 states have this in place).
    - Nursing students challenge to get clinicals and nurse practice legal issues when going out of state.

RECOMMENDATION:

- WA state representation at the November facilitated NCSBN meeting on compact status.
- Continue to explore background checks for WA State nurses.
- WA State to continue to attend these networking sessions at Annual Meeting.

2013 NCSBN Annual Meeting – Awards
August 15, 2013 Providence, Rhode Island
Submitted by NCQA commission member: Margaret E Kelly LPN

PURPOSE: The 35th NCSBN awards were presented at the 2013 Annual Meeting to recognize the outstanding achievements of NCSBN Members and Boards. The awards are designed to acknowledge significant contributions to nursing regulation. This was the 35th anniversary of NCSBN. During the award ceremony five Fellows were inducted into NCSBN Regulatory Excellence Institute (FRE). The purpose is to provide boards of nursing with high quality regulatory education, expanding the body of knowledge related to regulation through research and scholarly work, developing the capacity of regulators to become expert leaders, and developing a network of regulators who collaborate to improve regulatory practices and outcomes.

OUTCOME:

Susan L. Woods, PhD, RN, FAAN, commission member, Washington State Nursing Care Quality Assurance Commission, received the Exceptional Contribution Award.

Betsy Houchen, JD, MS, RN, executive director, Ohio Board of Nursing, the R. Louise McManus Award.

Constance Kalanek, PhD, RN, FRE, executive director, North Dakota State Board of Nursing, received the Meritorious Service Award.

Lorinda Inman, MSN, RN, former executive director, Iowa Board of Nursing received the Distinguished Achievement Award.

Linda R. Rounds, PhD, FNP, RN, FAANP, former board president, Texas Board of Nursing, received the Elaine Ellibee Award.

North Dakota Board of Nursing was awarded the Regulatory Achievement Award to recognize the board that significant contribution in promoting public policy related to the safe and effective practice of nursing in the interest of public welfare.

NCSBN Service awards given to:

Five Years: Julia George, MSN, RN, FRE, executive director, North Carolina

15 Years:

Paula Meyer, MSN, RN, executive director, Washington State Nursing Care Quality

Assurance Commission

Myra Broadway, JD, MS, RN, executive director, Maine State Board of Nursing

Constance Kalanek, PhD, RN, FRE, executive director, North Dakota State Board of Nursing

25 Years:

Lorinda Inman, MSN, RN, former executive director, Iowa Board of Nursing

Barbara Morvant, MN, RN, executive director, Louisiana State Board of Nursing

The following Boards of Nursing celebrating 100 years of nursing regulation in 2013:

Arkansas State Board of Nursing

College of Registered Nurses of Manitoba

Florida Board of Nursing

Montana State Board of Nursing

The 2013 class of IRE Fellows are:
Doreen Begley, MS, RN, FRE, former board member, Nevada State Board of Nursing
Jay Douglas, MSM, RN, CSAC, FRE, executive director, Virginia Board of Nursing
Jacinta MacKinnon, MN, RN, FRE, consultant, Registration Inquiry and Discipline, College of Registered Nurses of British Columbia
Kathleen Privette, MSN, RN, CNAA-BC, FRE, manager, Drug Monitoring Program, North Carolina Board of Nursing
Danielle Smith, MSN, RN, FRE, director of monitoring, Louisiana State Board of Nursing

RECOMMENDATION:

- NCQA Commission to continue to nominate members for recognition awards based on outstanding service to WA State and NCSBN.

Based on 2013Awards press release. For additional information see website for NCSBN.

NCSBN Annual Meeting
The Wit and Wisdom of Abraham Lincoln
Presented by Gene Griessman, PhD
August 15, 2013 Providence Island
Report Prepared by: Mindy Schaffner, PhD, MSN, CNS, RN

Purpose: The purpose of this presentation was to inform the audience of various lessons in President Lincoln's life that are applicable today. Dr. Griessman did an excellent job of telling the stories and relating them to the work done by Boards of Nursing.

Outcome: One of the main themes of this presentation was overcoming adversity and failures, as Lincoln had many of these in his life. The presenter used wit and the wisdom found in the multiple life experiences and speeches of Lincoln. President Lincoln was known for his story-telling and Dr. Griessman embedded many of these stories in his presentation. The speaker challenged the audience of nurse regulators to overcome adversities, to take a stand, and to move forward on difficult/unpopular issues that promote the quality of nursing care for the public.

Recommendations: Dr. Griessman would make an excellent speaker for future NCQAC events or conferences. He was entertaining, but provided substantive information that challenged his audience.

National Council of State Boards of Nursing – Annual Meeting
Executive Officer meeting, Delegate Assembly, and Elections
August 14-16, 2013 - Providence, Rhode Island
Paula R. Meyer, MSN, RN

PURPOSE:

A. Executive Officer Leadership Council Meeting: share issues across states and borders (with associate members), gather information and report back to group with recommendations for action.

B. Delegate Assembly: each member state has two delegates that vote on issues, motions and resolutions for the NCSBN.

C. Elections: the Leadership Succession Committee prepares the slate of candidates and the delegates vote. This year, candidates for area directors and members of the Leadership Succession Committee were elected.

OUTCOME:

A. Executive Officer Leadership Council Meeting

i. Barbara Morvant, LA-RN board of nursing, and Pat Noble, Maryland board of nursing, are retiring and were recognized.

ii. *The Practitioner's Guide to Governance as Leadership*, Cathy Trower. Insight into role definition and delineation of the board members and staff were presented. NCSBN purchased copies of the book for each board president and executive officer. Ms. Trower will be the featured speaker at the 2014 MidYear Leadership day.

iii. Nurses from Haiti – potential forged credentials affecting licensure in several states: California-RN, Missouri, Florida; group of five executive officers will assess the issue, work with the credential verification agencies (Josef Silvey, CGFNS), and bring a report back to the EO Leadership Council with recommendations

iv. Discussion related to non-nurse midwives, criminal background checks, relicensure of nurses whose license has been inactive for 10 years.

B. Delegate Assembly

i. Adopt the proposed 2014-2016 Strategic Initiatives: passed with 99% votes

ii. Adopt the proposed amendments to the NCSBN bylaws: passed with 95% votes

a. Motion to strike all references to public member and keep directors at large positions: passed with 77.1% of votes
b. Section V and VI of bylaws amended and approved
c. Section VII amended to retain Delegate Assembly approval: passed with 92% votes

iii. Adopt the proposed revision to the Member Board Agreement, effective October 2013: passed with 67% votes

iv. Approve setting the member board membership fee to zero upon adoption of the revised Member Board Agreement: passed with 95% votes

v. Adopt the Association of Registered Nurses of Newfoundland and Labrador as associate members: passed with 99% votes

vi. Adopt the College of LPNs of Manitoba as associate members: passed with 100% votes

vii. Adopt the Nursing and Midwifery Board of Ireland as associate members: passed with 100% votes.

viii. Adopt the proposed 2014 NCLEX-PN® Test Plan: passed with 100% votes

New business: Motion for the Board of Directors to explore electronic voting by the House of Delegates in the case of vacancies of the president and vice president: passed with 96.1% votes.

C. Election results

i. Board of Directors

a. Area I: Susan Odom, Idaho, board member

b. Area II: Lanette Anderson, West Virginia - PN, executive officer

c. Area III: Katherine Thomas, Texas, executive officer

d. Area IV: Ann L. O'Sullivan, Pennsylvania, board member

ii. Leadership Succession Committee

a. Designated Member, Board Member of NCSBN Member Board: Ann Coughlin, Pennsylvania, Area IV

b. Designated Member, Employee of NCSBN Member Board: Tony Graham, Mississippi, Area III

c. Designated Member, Former NCSBN Board of Directors Member: vacant, NCSBN Board of Directors will appoint

d. Designated Member, Current or Former NCSBN Committee Chair: Mark Majek, Texas, Area III

RECOMMENDATION: Continue to send at least one commission members and one staff person, in addition to the delegates, to the Annual Meeting. The 2014 annual meeting will be held in Chicago, August 13 – 15.

Washington State Nursing Care Quality Assurance Commission

Position Description

Commission Vice Chair Person

Qualifications:

Served on the Commission a minimum of one year on the day her or his term is to begin.
Demonstrated leadership characteristics by serving at least one of the following:

- Chair of a sub-committee
- Chair of a disciplinary panel
- Leadership in employment, association or community work

Duties and Responsibilities:

1. Assumes the duties of the Chair Person as needed.
2. Serves as a member of the Steering Committee.
3. Chairs the Legislative Task Force.
4. Provides assistance to the Chair Person and Executive Director as needed.
5. Participation with weekly Case Management Team meeting alternating with the Chair Person.
6. Boards and Commission Forum representation
7. NCSBN representation
8. Ongoing participation with commission duties with various task forces, committees, charging panels, hearings.
9. *Leads the development and implementation of the HB 1518 report and deliverables.*

Approved: 07/06, 07/08
Revised: 06/08
03/11

Washington State Nursing Care Quality Assurance Commission

Commission Member Expectations

RCW 18.79.010
Purpose

The nursing care quality assurance commission regulates the competency and quality of professional health care providers under its jurisdiction by establishing, monitoring, and enforcing qualifications for licensing, consistent standards of practice, continuing competency mechanisms, and discipline. Rules, policies, and procedures developed by the commission must promote the delivery of quality health care to the residents of the state of Washington.

1. Each commission member will attend all business meetings. Meetings are held on the second Friday of January, March, May, July, September and November unless otherwise scheduled by the commission. In order to conduct business, even discussing business on the agenda, a quorum of the commission must be present. If a commission member is unable to attend a meeting, the commission member must inform the commission chair and executive director at least 24 hours in advance of the meeting.
2. Attendance at all sub-committee and task force meetings is expected. Sub-committee and task force meetings are scheduled on an annual basis. If a commission member is not able to attend at the scheduled time, revisiting the schedule can be an agenda item. If a commission member is not able to attend a meeting, the commission member must communicate the absence to the chair of the sub-committee or task force. Recommendations for actions are considered at sub-committee and task force meetings. Attendance and participation are crucial to achieving consensus and presenting the recommendations at commission business meetings.
3. Each commission member is expected to be prepared for all meetings. Materials for the meetings are distributed prior to the meeting. If the materials are not received in a timely manner, the chair and staff person for the commission, sub-committee or task force need to be informed. Decisions made by the commission require every member to be fully informed.
4. Hearing dates are annually scheduled. Once a commission member volunteers for a hearing date, they must make themselves available on that date. Every hearing panel must have three members to make decisions.
5. Commission members must be inquisitive. If the materials, discussion or motion is not clear, commission members must ask questions. The outcomes of the decisions affect nursing practice in Washington.
6. The Uniform Disciplinary Act (UDA), RCW 18.130, is the basis for disciplinary action for all health professions in Washington. Every commission member must be familiar with the UDA. Staff attorneys are available on all charging panels for questions. As a reviewing commission member, use your staff attorneys for advice. In a hearing, the health law judge will review commission member responsibilities according to the UDA.
7. Excellence in our work is expected. If a commission member has concerns with the conduct or behaviors of a staff member, the commission member speaks with the

commission chair. The commission chair speaks with the executive director who guides and directs staff to improve performance.

If a staff member has concerns with the conduct or behaviors of a commission member, the staff person speaks with the executive director. The executive director brings the feedback to the attention of the commission chair. The commission chair and executive director work with the commission member to improve performance.

8. Meeting etiquette

a. At the beginning of all meetings, turn cell phones to silence mode. Breaks will be held and phone business can be conducted at that time.

b. Arrive on time and ready to begin meetings according to the start time on the agenda.

c. Stay for the full meeting. If a commission member is not able to arrive on time or stay the full meeting, the commission member must communicate this with the commission chair or the executive director.

d. Be engaged in the meeting. Listen to the presentations. Participate in the discussions and recommendations.

e. Side conversations at all meetings are not allowed.

9. Professional appearance and conduct

a. Dress for meetings is business attire. Dress as if the Governor will be attending.

b. Pay attention to the topics. Reading newspapers, doing crossword puzzles, texting personal messages, are not allowed.

c. Respect all members' contributions and time. Interruptions are to be kept to a minimum. The chair will recognize each member and allow time to speak.

d. The chair is responsible for conducting the business meetings and to enforce meeting etiquette, appearance and conduct.

e. Profanity is not allowed at any meetings.

Nursing Care Quality Assurance Commission

1518 Report

Revised Timeline, August 2013

June	July	August	September	October	November	December
Data gathering with Arizona State Board of Nursing	Complete RFP, choose contract recipient	Award contract Continue data collection, refinement	Steering committee to determine if more data needed	Develop recommendations based on data in DRAFT report	November 8: present DRAFT report to NCQAC for action	Distribution of report, meet with key legislators
Contact North Carolina Board of Nursing – plan to use their data for comparison	Data refined		DRAFT report Steering committee retreat 9/25 to review data and DRAFT report	Meet with health policy officer in Governor's office on data analysis and direction	If adopted by NCQAC, meet with DOH secretary to share report and recommendations	
Contract drafted for consultant to write report	Compare data among WA, AZ and NC		Steering committee to determine direction	Validate DRAFT report with AZ State Board of Nursing		
				Validate DRAFT report with NC Board of Nursing		

State Board of Nursing

OR

Nursing Care Quality Assurance Commission

RCW 18.79.090
Commission — Compensation.

Each commission member shall be compensated in accordance with RCW 43.03.265 and shall be paid travel expenses when away from home in accordance with RCW 43.03.050 and 43.03.060.

RCW 43.03.265
Compensation of members of part-time boards and commissions — Class five groups (as amended by 2011 c 5).

(1) Any part-time commission that has rule-making authority, performs quasi-judicial functions, has responsibility for the policy direction of a health profession credentialing program, and performs regulatory and licensing functions with respect to a health care profession licensed under Title 18 RCW shall be identified as a class five group for purposes of compensation.

Only health-related regulatory groups are considered class five: Chiropractic Quality Assurance Commission, Dental Quality Assurance Commission, Medical Quality Assurance Commission, Nursing Care Quality Assurance Commission. In the 2013 session, the legislature passed and the Governor signed House Bill 1609, changing the Board of Pharmacy to the Pharmacy Quality Assurance Commission.

(2) Except as otherwise provided in this section, each member of a class five group is eligible to receive compensation in an amount not to exceed two hundred fifty dollars for each day during which the member attends an official meeting of the group or performs statutorily prescribed duties approved by the chairperson of the group. A person shall not receive compensation for a day of service under this section if the person (a) occupies a position, normally regarded as full-time in nature, in any agency of the federal government, Washington state government, or Washington state local government; and (b) receives any compensation from such government for working that day.

(3) Compensation may be paid a member under this section only if it is necessarily incurred in the course of authorized business consistent with the responsibilities of the commission established by law.

(4) Beginning July 1, 2010, through June 30, 2011, no person designated as a member of a class five board, commission, council, committee, or similar group may receive an allowance for

subsistence, lodging, or travel expenses if the allowance cost is funded by the state general fund. Exceptions may be granted under section 605, chapter 3, Laws of 2010. Class five groups, when feasible, shall use an alternative means of conducting a meeting that does not require travel while still maximizing member and public participation and may use a meeting format that requires members to be physically present at one location only when necessary or required by law. Meetings that require a member's physical presence at one location must be held in state facilities whenever possible((~~, and~~)). Meetings conducted using private facilities must be approved by the director of the office of financial management, except for facilities provided free of charge.

(5) Beginning July 1, 2010, through June 30, 2011, class five groups that are funded by sources other than the state general fund are encouraged to reduce travel, lodging, and other costs associated with conducting the business of the group including use of other meeting formats that do not require travel.

[2011 c 5 § 906; 2010 1st sp.s. c 7 § 146; 1999 c 366 § 1.]

Notes:
Effective date -- 2011 c 5: See note following RCW 43.79.487.

RCW 43.03.265
Compensation of members of part-time boards and commissions — Class five groups (as amended by 2011 1st sp.s. c 21).

(1) Any part-time commission that has rule-making authority, performs quasi-judicial functions, has responsibility for the policy direction of a health profession credentialing program, and performs regulatory and licensing functions with respect to a health care profession licensed under Title 18 RCW shall be identified as a class five group for purposes of compensation.

(2) Except as otherwise provided in this section, each member of a class five group is eligible to receive compensation in an amount not to exceed two hundred fifty dollars for each day during which the member attends an official meeting of the group or performs statutorily prescribed duties approved by the chairperson of the group. A person shall not receive compensation for a day of service under this section if the person (a) occupies a position, normally regarded as full-time in nature, in any agency of the federal government, Washington state government, or Washington state local government; and (b) receives any compensation from such government for working that day.

(3) Compensation may be paid a member under this section only if it is necessarily incurred in the course of authorized business consistent with the responsibilities of the commission established by law.

(4) ((~~Beginning July 1, 2010, through June 30, 2011,~~)) No person designated as a member of a class five board, commission, council, committee, or similar group may receive an allowance for subsistence, lodging, or travel expenses if the allowance cost is funded by the state general fund. Exceptions may be granted under RCW 43.03.049 ((~~605, chapter 3, Laws of 2010~~)). Class five groups, when feasible, shall use an alternative means of conducting a meeting that does not require travel while still maximizing member and public participation and may use a meeting

format that requires members to be physically present at one location only when necessary or required by law. ((~~Meetings that require a member's physical presence at one location must be held in state facilities whenever possible, and meetings conducted using private facilities must be approved by the director of the office of financial management.~~))

(5) ((~~Beginning July 1, 2010, through June 30, 2011,~~)) Class five groups that are funded by sources other than the state general fund are encouraged to reduce travel, lodging, and other costs associated with conducting the business of the group including use of other meeting formats that do not require travel.

RCW 43.03.250
Compensation of members of part-time boards and commissions — Class four groups (as amended by 2011 c 5). ***(For example, The Veterinary Board of Governors).***

(1) A part-time, statutory board, commission, council, committee, or other similar group shall be identified as a class four group for purposes of compensation if the group:

(a) Has rule-making authority, performs quasi-judicial functions, or has responsibility for the administration or policy direction of a state agency or program;

(b) Has duties that are deemed by the legislature to be of overriding sensitivity and importance to the public welfare and the operation of state government; and

(c) Requires service from its members representing a significant demand on their time that is normally in excess of one hundred hours of meeting time per year.

(2) Each member of a class four group is eligible to receive compensation in an amount not to exceed one hundred dollars for each day during which the member attends an official meeting of the group or performs statutorily prescribed duties approved by the chairperson of the group. A person shall not receive compensation for a day of service under this section if the person (a) occupies a position, normally regarded as full-time in nature, in any agency of the federal government, Washington state government, or Washington state local government; and (b) receives any compensation from such government for working that day.

(3) Compensation may be paid a member under this section only if it is authorized under the law dealing in particular with the specific group to which the member belongs or dealing in particular with the members of that specific group.

(4) Beginning July 1, 2010, through June 30, 2011, class four groups, when feasible, shall use an alternative means of conducting a meeting that does not require travel while still maximizing member and public participation and may use a meeting format that requires members to be physically present at one location only when necessary or required by law. Meetings that require a member's physical presence at one location must be held in state facilities whenever possible((~~, and~~)). Meetings conducted using private facilities must be approved by the director of the office of financial management, except for facilities provided free of charge.

[2011 c 5 § 905; 2010 1st sp.s. c 7 § 145; 1984 c 287 § 5.]

Notes:

Effective date -- 2011 c 5: See note following RCW 43.79.487.

RCW 43.03.250

Compensation of members of part-time boards and commissions — Class four groups (as amended by 2011 1st sp.s. c 21).

(1) A part-time, statutory board, commission, council, committee, or other similar group shall be identified as a class four group for purposes of compensation if the group:

(a) Has rule-making authority, performs quasi-judicial functions, or has responsibility for the administration or policy direction of a state agency or program;

(b) Has duties that are deemed by the legislature to be of overriding sensitivity and importance to the public welfare and the operation of state government; and

(c) Requires service from its members representing a significant demand on their time that is normally in excess of one hundred hours of meeting time per year.

(2) Each member of a class four group is eligible to receive compensation in an amount not to exceed one hundred dollars for each day during which the member attends an official meeting of the group or performs statutorily prescribed duties approved by the chairperson of the group. A person shall not receive compensation for a day of service under this section if the person (a) occupies a position, normally regarded as full-time in nature, in any agency of the federal government, Washington state government, or Washington state local government; and (b) receives any compensation from such government for working that day.

(3) Compensation may be paid a member under this section only if it is authorized under the law dealing in particular with the specific group to which the member belongs or dealing in particular with the members of that specific group.

(4) ((~~Beginning July 1, 2010, through June 30, 2011,~~)) Class four groups, when feasible, shall use an alternative means of conducting a meeting that does not require travel while still maximizing member and public participation and may use a meeting format that requires members to be physically present at one location only when necessary or required by law. ((~~Meetings that require a member's physical presence at one location must be held in state facilities whenever possible, and meetings conducted using private facilities must be approved by the director of the office of financial management.~~))

RCW 43.03.240

Compensation of members of part-time boards and commissions — Class three groups (as amended by 2011 c 5). *(For example, the Board of Optometry, State Board of Health)*

(1) Any part-time, statutory board, commission, council, committee, or other similar group which has rule-making authority, performs quasi-judicial functions, has responsibility for the

administration or policy direction of a state agency or program, or performs regulatory or licensing functions with respect to a specific profession, occupation, business, or industry shall be identified as a class three group for purposes of compensation.

(2) Except as otherwise provided in this section, each member of a class three group is eligible to receive compensation in an amount not to exceed fifty dollars for each day during which the member attends an official meeting of the group or performs statutorily prescribed duties approved by the chairperson of the group. A person shall not receive compensation for a day of service under this section if the person (a) occupies a position, normally regarded as full-time in nature, in any agency of the federal government, Washington state government, or Washington state local government; and (b) receives any compensation from such government for working that day.

(3) Compensation may be paid a member under this section only if it is authorized under the law dealing in particular with the specific group to which the member belongs or dealing in particular with the members of that specific group.

(4) Beginning July 1, 2010, through June 30, 2011, no person designated as a member of a class three board, commission, council, committee, or similar group may receive an allowance for subsistence, lodging, or travel expenses if the allowance cost is funded by the state general fund. Exceptions may be granted under section 605, chapter 3, Laws of 2010. Class three groups, when feasible, shall use an alternative means of conducting a meeting that does not require travel while still maximizing member and public participation and may use a meeting format that requires members to be physically present at one location only when necessary or required by law. Meetings that require a member's physical presence at one location must be held in state facilities whenever possible((~~, and~~)). Meetings conducted using private facilities must be approved by the director of the office of financial management, except for facilities provided free of charge.

(5) Beginning July 1, 2010, through June 30, 2011, class three groups that are funded by sources other than the state general fund are encouraged to reduce travel, lodging, and other costs associated with conducting the business of the group including use of other meeting formats that do not require travel.

[2011 c 5 § 904; 2010 1st sp.s. c 7 § 144; 1984 c 287 § 4.]

Notes:
Effective date -- 2011 c 5: See note following RCW 43.79.487.
RCW 43.03.240
Compensation of members of part-time boards and commissions — Class three groups (as amended by 2011 1st sp.s. c 21).

(1) Any part-time, statutory board, commission, council, committee, or other similar group which has rule-making authority, performs quasi-judicial functions, has responsibility for the administration or policy direction of a state agency or program, or performs regulatory or licensing functions with respect to a specific profession, occupation, business, or industry shall

be identified as a class three group for purposes of compensation.

(2) Except as otherwise provided in this section, each member of a class three group is eligible to receive compensation in an amount not to exceed fifty dollars for each day during which the member attends an official meeting of the group or performs statutorily prescribed duties approved by the chairperson of the group. A person shall not receive compensation for a day of service under this section if the person (a) occupies a position, normally regarded as full-time in nature, in any agency of the federal government, Washington state government, or Washington state local government; and (b) receives any compensation from such government for working that day.

(3) Compensation may be paid a member under this section only if it is authorized under the law dealing in particular with the specific group to which the member belongs or dealing in particular with the members of that specific group.

(4) ((~~Beginning July 1, 2010, through June 30, 2011,~~)) No person designated as a member of a class three board, commission, council, committee, or similar group may receive an allowance for subsistence, lodging, or travel expenses if the allowance cost is funded by the state general fund. Exceptions may be granted under RCW 43.03.049 ((~~605, chapter 3, Laws of 2010~~)). Class three groups, when feasible, shall use an alternative means of conducting a meeting that does not require travel while still maximizing member and public participation and may use a meeting format that requires members to be physically present at one location only when necessary or required by law. ((~~Meetings that require a member's physical presence at one location must be held in state facilities whenever possible, and meetings conducted using private facilities must be approved by the director of the office of financial management.~~))

(5) ((~~Beginning July 1, 2010, through June 30, 2011,~~)) Class three groups that are funded by sources other than the state general fund are encouraged to reduce travel, lodging, and other costs associated with conducting the business of the group including use of other meeting formats that do not require travel.

RCW 43.03.230
Compensation of members of part-time boards and commissions — Class two groups (as amended by 2011 c 5).

(1) Any agricultural commodity board or commission established pursuant to Title 15 or 16 RCW shall be identified as a class two group for purposes of compensation.

(2) Except as otherwise provided in this section, each member of a class two group is eligible to receive compensation in an amount not to exceed one hundred dollars for each day during which the member attends an official meeting of the group or performs statutorily prescribed duties approved by the chairperson of the group. A person shall not receive compensation for a day of service under this section if the person (a) occupies a position, normally regarded as full-time in nature, in any agency of the federal government, Washington state government, or Washington state local government; and (b) receives any compensation from such government for working that day.

(3) Compensation may be paid a member under this section only if it is authorized under the law dealing in particular with the specific group to which the member belongs or dealing in particular with the members of that specific group.

(4) Beginning July 1, 2010, through June 30, 2011, no person designated as a member of a class two board, commission, council, committee, or similar group may receive an allowance for subsistence, lodging, or travel expenses if the allowance cost is funded by the state general fund. Exceptions may be granted under section 605, chapter 3, Laws of 2010. Class two groups, when feasible, shall use an alternative means of conducting a meeting that does not require travel while still maximizing member and public participation and may use a meeting format that requires members to be physically present at one location only when necessary or required by law. Meetings that require a member's physical presence at one location must be held in state facilities whenever possible((~~, and~~)). Meetings conducted using private facilities must be approved by the director of the office of financial management, except for facilities provided free of charge.

(5) Beginning July 1, 2010, through June 30, 2011, class two groups that are funded by sources other than the state general fund are encouraged to reduce travel, lodging, and other costs associated with conducting the business of the group including use of other meeting formats that do not require travel.

[2011 c 5 § 903; 2010 1st sp.s. c 7 § 143; 2001 c 315 § 11; 1984 c 287 § 3.]

Notes:
Effective date -- 2011 c 5: See note following RCW 43.79.487.
RCW 43.03.230
Compensation of members of part-time boards and commissions — Class two groups (as amended by 2011 1st sp.s. c 21).

(1) Any agricultural commodity board or commission established pursuant to Title 15 or 16 RCW shall be identified as a class two group for purposes of compensation.

(2) Except as otherwise provided in this section, each member of a class two group is eligible to receive compensation in an amount not to exceed one hundred dollars for each day during which the member attends an official meeting of the group or performs statutorily prescribed duties approved by the chairperson of the group. A person shall not receive compensation for a day of service under this section if the person (a) occupies a position, normally regarded as full-time in nature, in any agency of the federal government, Washington state government, or Washington state local government; and (b) receives any compensation from such government for working that day.

(3) Compensation may be paid a member under this section only if it is authorized under the law dealing in particular with the specific group to which the member belongs or dealing in particular with the members of that specific group.

(4) ((~~Beginning July 1, 2010, through June 30, 2011,~~)) No person designated as a member of

a class two board, commission, council, committee, or similar group may receive an allowance for subsistence, lodging, or travel expenses if the allowance cost is funded by the state general fund. Exceptions may be granted under RCW 43.03.049 ((~~605, chapter 3, Laws of 2010~~)). Class two groups, when feasible, shall use an alternative means of conducting a meeting that does not require travel while still maximizing member and public participation and may use a meeting format that requires members to be physically present at one location only when necessary or required by law. ((~~Meetings that require a member's physical presence at one location must be held in state facilities whenever possible, and meetings conducted using private facilities must be approved by the director of the office of financial management.~~))

(5) ((~~Beginning July 1, 2010, through June 30, 2011,~~)) Class two groups that are funded by sources other than the state general fund are encouraged to reduce travel, lodging, and other costs associated with conducting the business of the group including use of other meeting formats that do not require travel.

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE

Title:	Commission Pay	**Number:**	H04.02
Reference:	RCW 43.03.265, RCW 43.03-050 and RCW 43.03.060		
Contact:	Nursing Care Quality Assurance Commission		
Effective Date:	March 8, 2013		
Supersedes:	February 25, 2008		
Approved:	Paula R. Meyer, MSN, RN **Executive Director** **Nursing Care Quality Assurance Commission**		

PURPOSE STATEMENT:

Commission Members are compensated for performing duties consistent with their statutory responsibilities. This policy does not apply to travel reimbursement

PROCEDURE

1. The maximum compensation per day is $250.

In accordance with statute, compensation will not exceed $250 per day regardless of the length of time involved for that day, including travel time. All forms for commission compensation must be submitted to the Nursing Commission Office no later than the tenth of the month.

2. Less than eight hour days will be prorated.

Commission members receive compensation at the prorated hourly rate of $31.25 for less than eight hours in a single day.

3. Activities that will be compensated – examples.

The following activities are indicative of typical duties for which commission members will receive compensation:

- Commission business as appointed
- Attendance at commission and business meetings
- Reading commission meeting packets in preparation for meetings

- Telephone calls to and from staff, and participation in telephone conferences
- Reviewing case files and preparing for presentation(s) of the case
    - Reviewing journal articles directly related to a case*
    - Reviewing case summaries for Interim Review Panel (IRP)
    - Settlement conferences
    - Reviewing or editing Stipulation to Informal Disposition (STID), Agreed Orders, etc.
- Hearings not held during commission meetings
- Administrative activities performed by the Commission Chair
- Site visits*
- Public speaking engagements*
- Legislative hearings*
- New commission member orientation*

* Requires pre-approval by the Executive Director or their designee. See Section Four of this policy.

4. Some activities require pre-approval by the Executive Director.

Some duties, while beneficial to the public and community, may not be statutorily prescribed and may not be eligible for compensation by the program. Commission members should submit requests for compensation for these additional activities in advance.

The Executive Director will work with the Commission Chair to decide on appropriate compensation. This may include a review of the budget, adequate representation by other members, the strategic plan, and prioritizing requests.

Examples:

- Site visits
- Public speaking engagements
- Legislative hearings
- New Commission Member orientation
- Reviewing journals or articles directly related to a disciplinary case

Commission Member out-of-state travel. Out-of-state travel requires approval from the full commission, or the Executive Director in consultation with the Chair, and is subject to approval to the travel reservations being completed.

- Travel time to and from the meeting will be compensated

- If the meeting is less than eight hours, compensation will be pro-rated according to the time posted on meeting agenda(s).

5. Not all activities are eligible for compensation.

Some activities should be done on the commission member's own time and will not be reimbursed. Members are encouraged to seek clarification from the executive director prior to engaging in activities not specifically stated in statute.

Examples:

- Continuing education courses
- Travel time to and from official business if the member, by choice, deviated from the most efficient method
- Performing duties on behalf of the commission without informing the executive director
- Performing duties on behalf of the commission that have, or appear to have, a conflict of interest with the commission's official duties
- Attendance at meetings of specific ad hoc committees if not officially appointed
- Study time involving reading journals or articles, not directly related to case reviews
- Pre-payment of anticipated costs or business to be performed at a future date

6. Pro-Tem Members are compensated according to their scope.

Programs will compensate pro-tem commission members for duties stated in their appointment letter. Duties outside of their appointment scope may not be compensated.

7. If a Commission Member is a state employee or an employee of a municipality, a choice of payer must be made.

A public official must be paid from a single payer source. Therefore, if a Commission Member is an elected official or an employee of a state agency, school or a municipal government, the Commission Member must choose their payer source, or take leave from their payer source in order to be paid as a Commission Member. Individual Commission Members affected by this must communicate their choice for payment to the Executive Director within a month of their appointment.

Meeting Preparation Hours

2013		
Month	**Hours**	Total Members
May	17.50	6
July	26.00	9
September		
November		
January		
March		
Total	43.50	

NCQAC New Member Orientation Objectives

Presenter	Topic	Objectives
Paula Meyer	Overview of NCQAC, Public meetings, Ethics	1. Describe and distinguish between Nursing Commission authority and responsibilities and the Department of Health authority and responsibilities 2. List the commission members by appointment qualifications. Describe the appointment process, length of term and executive branch functions. 3. Describe the legal purpose and requirements for open public meetings. 4. Review organizational chart and identify key staff contacts 5. Describe the commission members' responsibilities and actions under the state ethics act.
Debbie Carlson	Nursing Practice	1. Describe the NCQAC authority to answer requests for definition of standards of nursing in WA 2. Describe the process used to determine individual scope of practice 3. Describe the functions and relationships among the Nursing Practice Advisory Groups, the Consistent Standards of Practice and the NCQAC

Mindy Schaffner	Nursing and Nursing Assistant Education	1. Identify NCQAC responsibilities defined in statute for nursing education programs and the nursing assistant programs 2. Identify NCQAC procedures for the approval, on-going review and complaint investigation for nursing education programs and nursing assistant training programs 3. Identify the two panels with decision-making authority for the NCQAC for nursing and nursing assistant education.
Anne Schuchmann	Budget, NCQAC pay, Rules	1. Name the law that defines the rules process and list several major requirements in the rules process. Describe the difference between a law and a rule. 2. Recognizes the limits of paying for a NCQAC member's time and expenses and personal time and expenses 3. Identify the revenue source for all actions provided by the NCQAC.
Gail Yu	Levels of evidence and recent court rulings Roles of staff attorneys and Assistant	1. Identify the different levels of evidence needed to support legal decisions. Give examples of clear and convincing evidence. Describe preponderance of evidence. 2. Distinguish among the role and functions of staff attorneys, assistant attorneys general prosecutor and assistant attorneys general advisor

Catherine Woodard/Mary Dale	Investigations Complaints, Discipline Process Case Management Process	1. List the steps in the disciplinary process 2. Identify the functions completed during each step of the disciplinary process 3. Identify the role of investigators and commission members
Laura Farris	Hearings: roles of commission members, health law judge Hearing process	1. Describe the role of the health law judge during administrative hearings 2. Describe the role of the commission members during administrative hearings
Teresa Corrado	Licensing Application process, Criminal Background Checks Continued Competency	1. Describe the licensing process from intake to review to approval. 2. Describe background checks completed on every licensing application and renewal and how the information is used 3. Describe continuing competency requirements for licensure renewal
Karl Hoehn	Legal Process	1. Describe a legal review of a case and how to use the review 2. Describe how to request legal advice from a staff attorney 3. Describe the difference between formal and informal action on a license
Louise Lloyd/Michael Hively	Use of computers	1. Complete confidentiality agreement and equipment responsibilities 2. Receive password and access device 3. Describe limitations of use of state equipment for state business only 4. Identify deadline for submitting pay and travel reimbursement forms as the 10th of each month 5. Review call calendar 6. Ensure they have phone list, etc.

Nursing Care Quality Assurance Commission

Education at Commission Meetings

September 2013

Responding to requests from the media

Criminal background checks

November 2013

Hearings process DVD

January 2014

Washington Health Professional Services – panel

a. Dr. John Furman
b. SUAT 2
c. NorthWest Organization of Nurse Executives
d. Washington State Nurses Association
e. Nursing Home Directors of Nursing

March 2014 – Simulation in nursing education and in testing nursing competency

a. NCSBN study on simulation
b. Arizona study on use of simulation in testing competency
c. CPEP testing for ARNPs

May 2014 – Performance Measures

a. Basis for performance measures
b. NCQAC measures and targets
c. Inclusion in strategic plan

RN Fees

	Current				New			
	Current Fee as of (7/1/13)	Washington Center for Nursing Surcharge	HEAL-WA Surcharge	Total Fee	Proposed Fee Changes (1/1/14)	Washington Center for Nursing Surcharge	HEAL-WA Surcharge	Total Fee
Application	$ 67	$ 5	$ 16	$ 88				
Renewal	$ 76	$ 5	$ 16	$ 97				
Late Renewal	$ 50			$ 50				
Renewal (Retired Active)					$ 45	$ 5	$ 16	$ 66
Late Renewal (Retired Active)					$ 23	$ 5	$ 16	$ 44
Inactive Renewal	$ 40			$ 40				
Inactive Late Renewal Penalty	$ 30			$ 30				
Expired License Reissuance	$ 70			$ 70				
Expired Inactive Reissuance	$ 40			$ 40				
Duplicate License	$ 20			$ 20				
Written Verification of Licensure/Education	$ 25			$ 25				

LPN

	Current				New			
	Current Fee as of (7/1/13)	Washington Center for Nursing Surcharge	HEAL-WA Surcharge	Total Fee	Proposed Fee Changes (1/1/14)	Washington Center for Nursing Surcharge	HEAL-WA Surcharge	Total Fee
Application	$ 87	$ 5		$ 92	$ 67	$ 5	$ 16	$ 88
Renewal	$ 91	$ 5		$ 96	$ 75	$ 5	$ 16	$ 96
Late Renewal	$ 50			$ 50				
Renewal (Retired Active)					$ 45	$ 5	$ 16	$ 66
Late Renewal (Retired Active)					$ 23	$ 5	$ 16	$ 44
Inactive Renewal	$ 40			$ 40				
Inactive Late Renewal Penalty	$ 30			$ 30				
Expired License Reissuance	$ 70			$ 70				
Expired Inactive Reissuance	$ 40			$ 40				
Duplicate License	$ 20			$ 20				
Written Verification of Licensure/Education	$ 25			$ 25				

ARNP

	Current				New			
	Current Fee as of (7/1/13)	Washington Center for Nursing Surcharge	HEAL-WA Surcharge	Total Fee	Proposed Fee Changes (1/1/14)	Washington Center for Nursing Surcharge	HEAL-WA Surcharge	Total Fee
Application	$ 92			$ 92				
Renewal	$ 96			$ 96				
Late Renewal	$ 50			$ 50				
Duplicate License	$ 20			$ 20				
Written Verification of Licensure/Education	$ 25			$ 25				

Sub-committee structure and reporting to the Nursing Commission

Sub-committees 'do the work' of the commission and present their work to the full commission for actions and decisions. The commission has the authority to make the decisions – the sub-committees do not. The sub-committee formulate recommendations and only the full commission can take action. (See below for actions under the Uniform Disciplinary Act)

1. Is a quorum needed at sub-committee meetings?
   Not really. But, you want your members to be present and consensus on your recommendations to the full commission for action.
2. Who adopts and approves the minutes of the subcommittees?
   The commission adopts the minutes. The minutes are reviewed by the subcommittee and recommended to the commission for adoption on the consent agenda.
3. What is the consent agenda?
   Items on the consent agenda are considered routine business and all items can be adopted with a single motion and vote. If discussion of one or more items is requested, that item is pulled from the consent agenda. The remaining items can be voted as a single item. Then, proceed to discuss the item pulled from the agenda.
4. When the sub-committee presents a motion, it comes with a second. Why isn't a separate second to the motion needed?
   The motion comes from the committee, not a single commission member. In other words, the committee members are making the motion and second because there is more than one member on the sub-committee. Therefore, the sub-committee members attendance and participation in the meetings to achieve consensus on items is very important.
5. If participation at the meetings is an issue, the chair of the sub-committee works with the individual. Times and dates can be changed if needed. Communication with Louise Lloyd must occur if there are changes in dates and times of meetings. Louise communicates the changes with the state operator to assure the conference call occurs at the right time and the members have the call in number and PIN.
6. What is the staff member's role?
   The staff member is there to assist the sub-committee in their work. The staff member takes assignments, completes the assignments between sub-committee and commission meetings. The staff member works with the sub-committee chair on the agenda and the minutes. The chair of the sub-committee presents the report and recommendations from the sub-committee to the full commission at the business meetings. If the chair is not available for the meeting, another sub-committee member is appointed to present the report.

SUPPLEMENTAL REPORT – NURSING CARE QUALITY ASSURANCE COMMISSION
August 2013

The mission of the Nursing Care Quality Assurance Commission is to regulate the competency and quality of licensed practical nurses, registered nurses and advanced registered nurse practitioners by establishing, monitoring and enforcing qualifications for licensing, consistent standards of practice, continuing competency mechanisms, and discipline. The commission establishes standards for approval and evaluation of nursing education programs.

Members appointed to the nursing commission may serve two four-year terms. The commission consists of two ARNPs, seven RNs, three LPNs, and three public members.

The commission participated in a five year pilot project that resulted with legislation passed (SSHB 1518) in 2013 making the pilot project permanent.

Advanced Registered Nurse Practitioner Subcommittee

The ARNP consultant and commission have worked together to complete and approve (a) Guidelines for appropriate sanctions for ARNPs in the disciplinary process, (b) interpretive statements to clarify the Non-Cancer Pain Management Rules, and (c) expedited processes for staff to complete licensing from out of state ARNPs, when requirements from the other state do not align with those of Washington. In addition, the commission has developed a process of classification and tracking of inquiries for analysis. This will allow for quality control of response time and appropriate development of FAQs to reduce the time of answering inquiries.

Continuing Competency

The Continuing Competency Subcommittee established the procedure for continuing competency audits. The commission created and filled the position of the compliance officer in preparation for the 2014 audits to begin. Documents, letters, and procedures were created to include diagrams. The commission drafted rules for "retired active status" with continuing competency requirements. A continuing competency webpage was completed and frequently asked questions posted.

Consistent Standards of Practice

The Consistent Standards of Practice Subcommittee addresses consistent standards of practice across professional nursing in the State. The subcommittee monitors practice, discipline trends and patient safety concerns with the goal of safer practices and better patient outcomes. The subcommittee partners with clinical expertise to direct practice improvement across the nursing profession. Nurse Practice Advisory Groups, established by the subcommittee, assist in developing draft interpretive statements and advisory opinions for the Nursing Commission's consideration.

Licensing and Discipline

The commission has improved efficiencies in discipline through revisions of existing processes and procedures.

An audit of the commission approved substance abuse monitoring program, Washington Health Professional Services (WHPS), was completed. The commission reviewed the audit and the procedures

manual for the WHPS program, and are providing input to the program. A team worked to develop a more efficient and effective procedure to resolve disciplinary cases that meet criteria to enter the program. The commission adopted this procedure that protects the public by allowing the commission to take quick action should a participant fail the WHPS program.

The commission evaluated the Early Remediation Program and implemented changes to improve the program. This program allows non-disciplinary resolution of clinical practice deficiency cases that meet certain criteria. Nurses in this program must complete requirements, such as education or monitoring, to remedy the deficiencies.

The commission revised the procedure that sets criteria for closing cases as "below threshold" to allow additional closure of cases with low harm. Not investigating low harm cases makes better use of the commission resources.

The weekly Case Management Team that assesses all complaints against nurses now uses electronic meetings, and sends all documents to members electronically. This process is more efficient and makes the transfer of documents safer.

2012 and 2013 Fiscal Year Renewal Numbers

Fiscal Year 2012	Number of Renewals	Fiscal Year 2013	Number of Renewals
RN	77,532	RN	79,082
LPN	12,148	LPN	12,010
ARNP	2,552	ARNP	3,204
NTEC	176	NTEC	150
Total	92,408	Total	94,446

Total difference - 2,038 = 9.78% Increase

2012 and 2013 Fiscal Year Application Numbers

Fiscal Year 2012	Number of Applications	Fiscal Year 2013	Number of Applications
RN	8,082	RN	8,939
LPN	1,411	LPN	1,639
ARNP	505	ARNP	684
NTEC	247	NTEC	234
Total	10,245	Total	11,496

Total Difference - 1,251 = 12% increase

Nursing Investigations

The commission has significantly reduced the backlog of open investigations by targeting investigations for completion, improving existing procedures to allow for less-involved investigation under certain circumstances, and changing the report format to streamline the report writing process.

Investigators worked each month towards specific goals of balancing the completion of investigations within timelines while completing the oldest cases already outside timelines. This brought us to where we are today, with consistently fewer than 10% of the cases outside timelines and most completed within 170 days.

Through active participation on the Substance Use and Abuse Team (SUAT), investigators worked with legal and discipline staff to streamline substance abuse investigations. Investigators collect all records as necessary to prove drug diversion; however, under the circumstances of a positive drug test and admission to substance abuse, the investigator may invite the respondent to sign an agreement to enter the approved substance abuse monitoring program.

Investigative reports shifted from the global, "telling a story" format to a crisp, concise, bulleted format of presenting facts for the commission to consider. The result is a report that is easier to read, easier to understand, and easier for the investigator to write. The new reports take less time to write and allow the investigator more time to focus on other aspects of the investigation.

Fees and Fiscal Matter

During the 2011-13 biennium, the Nursing Commission accomplished its mission and goals with numerous state budget restraints in place.

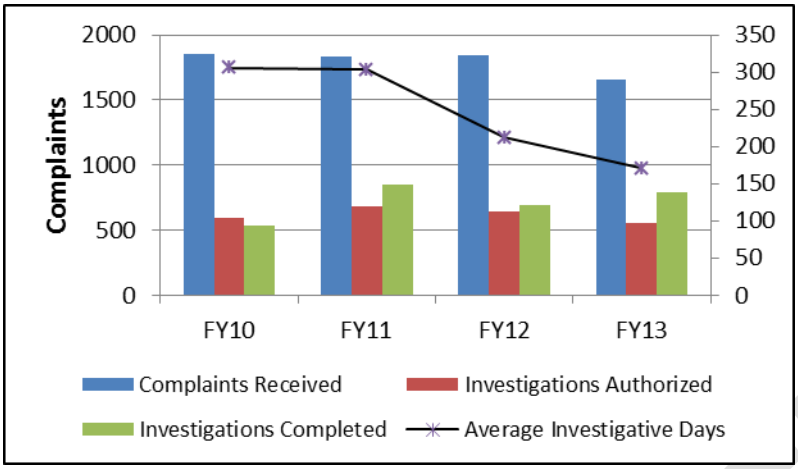
In 2013, legislation passed allowing licensed practical nurses (LPN), for a fee of $16, access to research resources at the University of Washington's health sciences library.

In lieu of adding an additional application or renewal fee to their license to cover the cost, the commission lowered LPN fees by $16 to offset the surcharge. To better align with renewal fees for registered nurses (RN), the commission reduced LPN renewal fees by $4.

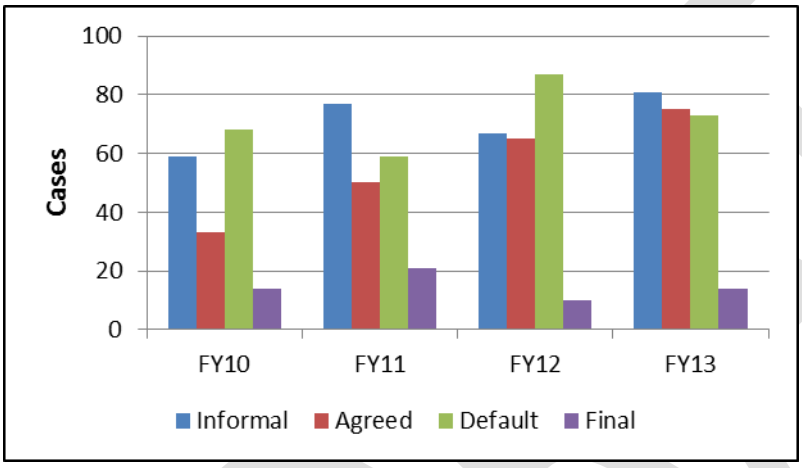
A new license status of "retired active" for RNs and LPNs, with an associated reduced fee, is in process. The proposed change would allow retired nurses to provide care in emergent or intermittent circumstances.

All other nursing fees have remained the same since 2010.

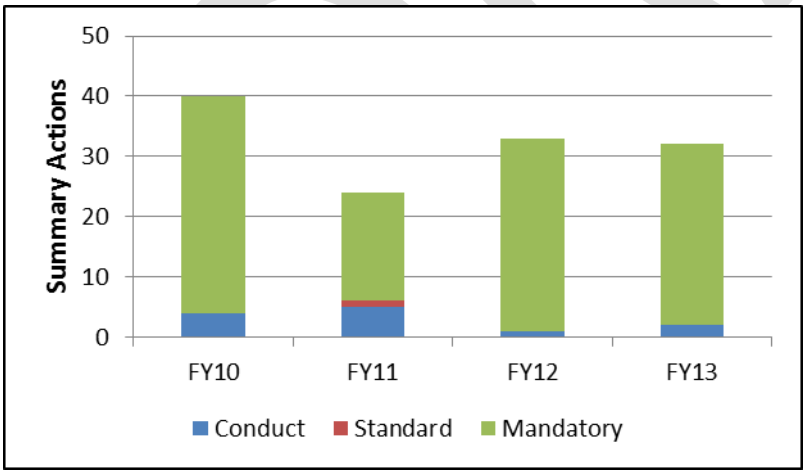
Complaints



The number of complaints and investigations authorized during 2011-2013 remains consistent with previous biennia. The number of investigations completed has grown as we have reduced the backlog of cases. Efficiencies in case management and investigation procedures have reduced the time it takes to complete an investigation.



Cases closed with action have steadily increased in the last four years. During the last fiscal year, the number of informal, agreed, and default orders are nearly equal.



Most nursing summary suspensions in Washington are issued based on action in another state. The nursing profession has a low percentage of summary suspensions for conduct.

TO: Paula Meyer

FROM: Mary Dale

DATE: August 26, 2013

SUBJECT: Agenda Item V.I

Discipline Policies and Procedures

Staff reviewed all nursing discipline policies and procedures. The only changes made were changing the date and version numbers. These are brought to the commission for signature of the chair. They are not included in the packet, but are available upon request. The following procedures are updated and brought for signature:

A01.03 Sign Withdrawal of Charges

A20.06 Substance Abuse Orders

A24.09 Approval of Evaluators in Nurse Discipline Cases

A25.04 Panels for Decision Making

A28.05 Disciplinary Orders

A29.03 List and Labels

A34.04 Early Remediation Program

A40.02 Safe to Practice

A41.02 Investigative Mental and/or Physical Examinations

A42.02 Licensee HIV-AIDS Status

A43.02 Military Status

A44.02 Withdrawal of Statement of Allegations

A45.02 Withdrawal of Statement of Charges

A46.02 Summary Actions

A47.02 Surrender of Credential

A48.02 Case Status Correspondence

A49.02 Substance Abuse Referral Contracts

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE

Title:	Signing Withdrawal of Charges Document	**Number:**	A01.03
Reference:			
Contact:	Mary Dale, Discipline Manager		
Effective Date:	September 13, 2013		
Supersedes:	July 20, 1995; July 1, 2005		
Approved:			
	Chair **Washington State Nursing Care Quality Assurance Commission**		

PURPOSE:

This procedure will delegate signature authority to staff for Withdrawal of Charges documents.

PROCEDURE:

Staff may sign Withdrawal of Charges documents. This will be allowed for investigative files where the Reviewing Commission Member (RCM) has designated the issuance of a Statement of Charges (SOC) and then has performed a second review and determined that the file meets the criteria for "less serious" charges.

The RCM determines the need for a SOC and then determines that the SOC should be withdrawn. Staff is not involved in the decision process.

Revised 07/01/2005

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
POLICY

Title:	Substance Abuse Orders	**Number:**	A20.06
Reference:	RCW 18.130.175; RCW 18.130.170 ; 18.130.180; WAC 246-840-780; WAC 246-840-770; WAC 246-840-740		
Contact:	Paula R. Meyer, Executive Director		
Effective Date:	September 13, 2013		
Supersedes:	April 14, 2000; July 15, 2000; March 11, 2005; July 1, 2005; September 9, 2011		
Approved:			
	Chair **Washington State Nursing Care Quality Assurance Commission**		

POLICY:

The Nursing Care Quality Assurance Commission (NCQAC) supports the following principles:

- Chemical dependency is a treatable condition
- A chemically impaired nurse should have an opportunity to return from addiction to recovery
- Appropriate and effective treatment can save a professional's career, license, and even his/her life
- Participation in monitoring programs for chemically impaired nurses leads to successful recovery for the impaired practitioner while providing maximal protection of the public safety
- Monitoring chemically impaired nurses requires specialized education and knowledge
- Public protection is best addressed through consistent approaches to discipline

While the NCQAC maintains full authority to tailor sanctions to individual cases, the approaches outlined below are strongly recommended.

PROCEDURE:

1. In cases where a nurse has committed unprofessional conduct, and the violation was likely the result of chemical dependency or substance abuse, the nurse will be referred to a NCQAC approved substance abuse monitoring program for chemically impaired professionals ("monitoring program") that meets the requirements of WAC 246-840-770. Approved monitoring programs include the Washington Health Professional Services Program (WHPS) and equivalent monitoring programs approved by Nursing Boards or Commissions in other states.

2. A Reviewing Commission Member (RCM) evaluates all investigative files involving unprofessional conduct related to chemical dependency or substance abuse. The RCM presents the case to a Case Disposition Review Panel ("Panel") for possible disciplinary action.

   2.1. The Panel may decide not to authorize discipline against a nurse's license so long as the nurse enters the monitoring program in a timely manner and complies with the terms of the monitoring contract. The nurse may be required to sign a Substance Abuse Referral Contract (SARC) in accord with WAC 246-840-780 as a precondition of the Panel's decision to close the case without disciplinary action. Under these circumstances, the nurse enters the monitoring program "in lieu of discipline," and the case is closed as a "Unique Closure."

   2.2. In the event the investigation reveals serious misconduct, the NCQAC takes disciplinary action to protect the public. Serious misconduct may include, but not be limited to:

      2.2.1. Abuse of a patient
      2.2.2. Theft of money or property (other than drugs) from a patient or family member
      2.2.3. Arrest or conviction as defined in Policy A21
      2.2.4. Sexual contact or boundary violations as defined in WAC 246-840-740
      2.2.5. Gross incompetence seemingly not related to drug or alcohol abuse

   2.3 This procedure does not prohibit expedited case closure at the case management level when appropriate per existing policy A22.

3. If a nurse enters the monitoring program voluntarily and is referred to the NCQAC for noncompliance with the monitoring contract, the case may be assessed by a Substance Use and Abuse Team in order to expedite case resolution. If there is no evidence of misconduct related to nursing practice or there is insufficient evidence to proceed with any action, the case will be closed under the appropriate closure code and remain closed.

4. If a nurse who initially entered the monitoring program in lieu of discipline is referred back to the NCQAC by the monitoring program for noncompliance with the terms of the monitoring contract, a Substance Use and Abuse Team (SUAT) will assess the case and make a recommendation about setting the case's priority and the appropriate scope of the investigation. If there is evidence of unprofessional conduct, the NCQAC should serve a Statement of Allegations (SOA), and offer a Stipulation to Informal Disposition (STID). The

SOA may cite the underlying drug related misconduct as well as any misconduct pertaining to the noncompliance. Additionally, if the nurse signed a Substance Abuse Referral Contract as a condition of the Panel's decision to uniquely close the original case, the NCQAC may also cite violation of the Substance Abuse Referral Contract, which is a violation of RCW 18.130.180 (7) and WAC 246-840-780. If the nurse is eligible to re-enter the monitoring program, the STID shall state the condition that they be referred back to the monitoring program, enter into a new monitoring contract, and comply with any and all agreed treatment and monitoring conditions.

5. The terms of the STID will be satisfied when the nurse successfully completes the approved monitoring program.

6. If the nurse signs a STID, but does not remain in good standing with the monitoring program, and is not eligible to re-enter the monitoring program, the NCQAC proceeds with a Statement of Charges (SOC) based upon substantial non-compliance with an Order (the STID). The action results in an unstayed suspension with a minimum length of 24 months. To petition for reinstatement, the nurse must demonstrate:

    6.1 at least 24 consecutive months of abstinence documented by random observed biological fluid testing, to include ETG/ETS (at least 12 tests per year) and hair testing, if hair testing is deemed necessary by the Reviewing Commission Member, by an independent, licensed testing entity;
    6.2 completion of chemical dependency treatment;
    6.3 participation in professional peer support groups and NA/AA; and
    6.4 a recent (within 90 days of petitioning for reinstatement) chemical dependency evaluation by a NCQAC approved evaluator. The evaluation shall include:

    A. respondent's condition or diagnosis;
    B. conclusions and prognosis;
    C. recommendations regarding the need for ongoing care and treatment; and
    D. professional opinion regarding Respondent's ability to practice nursing with reasonable skill and safety.

7. If a nurse does not agree to a STID to enter into the monitoring program, but instead proceeds to a hearing where it is determined the nurse committed professional misconduct with a finding that the nurse misused drugs or alcohol or other finding substantiating a substance abuse problem, the NCQAC should not issue orders containing multiple substance abuse conditions, but rather:

    7.1 In less serious cases, when approved by the Commission, the nurse may enter into an agreed order (settlement) to enter the monitoring program for monitoring and treatment.

    7.2 If there is no such agreement, or in more serious cases, the final order should result in an unstayed suspension, without the ability to petition for reinstatement for a minimum of 24 months. To petition for reinstatement, the nurse must demonstrate at least 24 consecutive months of abstinence documented by random

observed biological fluid testing, to include ETG/ETS (at least 12 tests per year) and hair testing, if hair testing is deemed necessary by the Reviewing Commission Member, by an independent, licensed testing entity, completion of chemical dependency treatment, participation in professional peer support groups and NA/AA, and provide a recent (within 90 days of petitioning for reinstatement) chemical dependency evaluation by a commission - approved evaluator.

8. A Statement of Charges (SOC) should be issued in any case where the nurse obtained drugs in violation of RCW 18.130.180(6), including diversion or violation of any drug laws, where the evidence indicates the nurse is prescribing, selling, or distributing drugs to others and is not personally using or addicted.

ATTACHMENT- SUBSTANCE ABUSE REFERRAL CONTRACT (SARC)

SUBSTANCE ABUSE REFERRAL CONTRACT

A complaint(s) alleging unprofessional conduct has been filed with the Nursing Care Quality Assurance Commission (NCQAC) against _____, (Respondent). The Nursing Care Quality Assurance Commission has reason to believe that the alleged unprofessional conduct may be the result of substance use and/or abuse.

In return for Respondent entering the Washington Health Professional Services Program (W.H.P.S.), the NCQAC agrees to take no disciplinary action against Respondent's credential regarding case number/file number _____ as long as Respondent complies with all of the terms of this Substance Abuse Referral Contract and successfully completes the W.H.P.S. program.

By signing this Substance Abuse Referral Contract, Respondent admits to the truthfulness of the investigative report for case number/file number _____ and agrees to the admissibility of the evidence contained therein.

1. On or before seven (7) calendar days of signing this Substance Abuse Referral Contract, Respondent must contact W.H.P.S. and begin the process of signing a W.H.P.S. Monitoring Contract and enrolling in the W.H.P.S. program.[1]

2. The length of the W.H.P.S. Monitoring Contract will be up to the sole discretion of the W.H.P.S. program. Contracts generally have a term of five (5) years. The W.H.P.S. program's recommendation to enter into a monitoring contract and the term of the monitoring contract is not based exclusively upon a substance abuse evaluation.

3. Respondent must execute a W.H.P.S. Monitoring Contract on or before forty-five (45) calendar days of signing this Substance Abuse Referral Contract.

4. Respondent agrees to comply with <u>all</u> aspects of the W.H.P.S. program which may include, but are not limited to:

(a) undergoing intensive substance abuse treatment in an approved treatment facility

(b) remaining free of all mind-altering substances including alcohol except for medications prescribed by an authorized prescriber, as defined in RCW 69.41.030 and 69.50.101

(c) completing the prescribed aftercare, which may include individual and/or group psychotherapy

[1] Washington Health Professional Services
P.O. Box 47872
Olympia, WA 98504-7872
Phone: 360-236-2880 Fax: 360-664-8588
WHPS@doh.wa.gov

(d) causing the treatment counselor(s) to provide reports that include treatment prognosis and goals to the W.H.P.S. program at specified intervals

(e) submitting to random drug screening as specified by the W.H.P.S. program

(f) attending recovery support groups as specified by the W.H.P.S. program

(g) complying with specified employment conditions and restrictions as defined by the W.H.P.S. Monitoring Contract to include notifying W.H.P.S. and receiving approval prior to a change in work status, shift, employment position, or place of employment.

(h) signing a waiver allowing the W.H.P.S. program to release information to the NCQAC if the nurse does not comply with the requirements of the W.H.P.S. Monitoring Contract or is unable to practice with reasonable skill or safety

5. Respondent is responsible for paying all costs associated with participation in W.H.P.S.

6. Respondent shall report to the NCQAC if he/she fails to comply with this Substance Abuse Referral Contract or with his/her W.H.P.S. Monitoring Contract.

7 Respondent will be subject to disciplinary action under RCW 18.130.160 if he/she does not comply with all aspects of the W.H.P.S. program, his/her specified employment restrictions, or this Substance Abuse Referral Contract.

RESPONDENT	DATE	LICENSE NUMBER
PANEL CHAIR	DATE	
W.H.P.S. REPRESENTATIVE	DATE	

SUBSTANCE ABUSE REFERRAL CONTRACT

A complaint(s) alleging unprofessional conduct has been filed with the Nursing Care Quality Assurance Commission (NCQAC) against , (Respondent). The Nursing Care Quality Assurance Commission has reason to believe that the alleged unprofessional conduct may be the result of substance use and/or abuse.

In exchange for Respondent signing this agreement and entering the Washington Health Professional Services Program (W.H.P.S.), the NCQAC agrees to take no disciplinary action against Respondent's credential regarding case file number as long as Respondent complies with all of the terms of this Substance Abuse Referral Contract and successfully completes the W.H.P.S. program.

By signing this Substance Abuse Referral Contract, Respondent admits to the truthfulness of the investigative evidence in case file number and agrees to the admissibility of the evidence contained therein.

1. Within seven (7) calendar days of Respondent signing this Substance Abuse Referral Contract, Respondent must contact W.H.P.S. and begin the process of signing a W.H.P.S. Monitoring Contract and enrolling in the W.H.P.S. program.[1]

2. On or before forty-five (45) calendar days of Respondent signing this Substance Abuse Referral Contract, Respondent must execute a W.H.P.S. Monitoring Contract.

3. The length of the W.H.P.S. Monitoring Contract will be up to the sole discretion of the W.H.P.S. program. Contracts generally have a term of five (5) years. The W.H.P.S. program's recommendation to enter into a monitoring contract and the term of the monitoring contract is not based exclusively upon a substance abuse evaluation.

4. Respondent agrees to comply with <u>all</u> aspects of the W.H.P.S. program which may include, but are not limited to:

(a) undergoing intensive substance abuse treatment in an approved treatment facility

(b) remaining free of all mind-altering substances including alcohol except for medications prescribed by an authorized prescriber, as defined in RCW 69.41.030 and 69.50.101

(c) completing the prescribed aftercare, which may include individual and/or group psychotherapy

[1] Washington Health Professional Services
P.O. Box 47872
Olympia, WA 98504-7872
Phone: 360-236-2880 Fax: 360-664-8588
WHPS@doh.wa.gov

(d) causing the treatment counselor(s) to provide reports that include treatment prognosis and goals to the W.H.P.S. program at specified intervals

(e) submitting to random drug screening as specified by the W.H.P.S. program

(f) attending recovery support groups as specified by the W.H.P.S. program

(g) complying with specified employment conditions and restrictions as defined by the W.H.P.S. Monitoring Contract to include notifying W.H.P.S. and receiving approval prior to a change in work status, shift, employment position, or place of employment.

(h) signing a waiver allowing the W.H.P.S. program to release information to the NCQAC if the nurse does not comply with the requirements of the W.H.P.S. Monitoring Contract or is unable to practice with reasonable skill or safety

5. Respondent is responsible for paying all costs associated with participation in W.H.P.S.

6. Respondent shall report to the NCQAC if he/she fails to comply with this Substance Abuse Referral Contract or with his/her W.H.P.S. Monitoring Contract.

7. Respondent will be subject to disciplinary action under RCW 18.130.160, RCW 18.130.180 and WAC 246-840-780 if he/she does not comply with all aspects of the W.H.P.S. program, his/her specified employment restrictions, or this Substance Abuse Referral Contract.

8. The NCQAC will not sign this Substance Abuse Referral Contract or close Respondent's disciplinary case until Respondent has signed a W.H.P.S. Monitoring Contract.

RESPONDENT	DATE	LICENSE NUMBER
PANEL CHAIR	DATE	
W.H.P.S. REPRESENTATIVE	DATE	

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
POLICY

Title:	Approval of Evaluators in Nurse Discipline Cases	**Number:**	A24.09
Reference:	RCW 18.79; RCW 18.130		
Contact:	Paula R. Meyer, Executive Director		
Effective Date:	September 13, 2013		
Supersedes:	September 13, 2002; July 1, 2005; July 13, 2007; Nov 14, 2008; November 13, 2009; May 14, 2010; September 6, 2011		
Approved:			
	Chair **Washington State Nursing Care Quality Assurance Commission**		

PURPOSE:

The NCQAC approves evaluators qualified to conduct mental and/or physical health, sexual deviancy, sexual or other misconduct, boundary violations, or any other applicable specialty evaluations on licensed nurses. Such evaluations may be required in Interim Orders, Agreed Orders and Final Orders. Nursing Care Quality Assurance Commission (NCQAC) staff may refer approved evaluators to licensees. The NCQAC reviews and revises the list of approved evaluators on a periodic basis. Additional approved evaluators may be added to the list.

PROCEDURE:

1. Requests to add or delete evaluators are forwarded to the Disciplinary Manager. Updates and deletions may be completed by the manager.
2. The Disciplinary Manager ensures all required documents are submitted. The Discipline Manager adds revision of the evaluator list to the agenda for the next Licensing & Disciplinary Subcommittee meeting.
3. The Disciplinary Manager sends copies of the applications documents to the subcommittee members, along with the current policy.
4. The subcommittee evaluates the documents and determines if the applicant meets the minimum standards.
5. The Disciplinary Manager updates the list.

Evaluator Minimum Standards:

1. Licensed in the State of Washington for at least two (2) years in one of following specialties: Board Certified Psychiatrist, Board Certified Physician, Psychologist with a PhD, Advanced Registered Nurse Practitioner holding national certification in the area of specialization, certification as a Sexual Offender Treatment Provider and/or certification as a Mental Health Evaluator;
2. No disciplinary action in any state;
3. Minimum of five (5) years of experience in assessment and treatment in area of specialization;
4. Present a current curriculum vitae reflecting formal education, work and research experience, professional activities and specialized training;
5. Knowledge of nursing practice and/or experience in evaluating nurses and other health professionals is desirable;
6. Agree to schedule a licensee for evaluation within a reasonable time period and to complete and submit the evaluation to meet the schedule of the Order; and
7. Submit a writing sample of a completed evaluation (names redacted).

Certain exceptions to the evaluator minimum standards may be approved by the Licensing and Discipline Subcommittee.

PROTOCOL FOR CONDUCTING A MENTAL/PHYSICAL HEALTH EVALUATION ON A LICENSED NURSE

I. The scope and content of a mental/physical health evaluation must include consideration of the following when rendering your professional opinion regarding the Respondent's ability to practice nursing with reasonable skill and safety.

A. A complete history of the Respondent, including physical, mental, social, developmental, medical, psychiatric or psychological factors. Review of Respondent's medical records, including physical and mental health records. Review of Respondent's medication history, especially use of mind-altering and/or psychotropic medications.

B. Appropriate and sufficient evaluation and testing to fully assess the Respondent's physical and mental condition, including but not limited to:

1. Cognitive ability: Nursing requires the ability to analyze and synthesize complex scientific, clinical, diagnostic, quantitative and qualitative data quickly and accurately. Evaluation should include Respondent's critical thinking skills, judgment and problem-solving ability, decision-making, prioritization and organizational skills;
2. Mental acuity, alertness, memory: Ability to be present and aware; to observe and rapidly assess a situation and develop a reasonable plan of action; divided attention skills. Ability to retain and recall essential and pertinent information;
3. Communication and Comprehension: Ability to comprehend and communicate effectively, both verbally and in writing, including auditory comprehension and listening skills;
4. Ethics and moral character: Truthfulness, compassion, empathy, selflessness, ability to maintain professional boundaries;
5. Stress and management: Ability to manage stress and anger effectively;

6. Physical ability: Physical strength and stamina, manual dexterity, mechanical ability;
7. Special Conditions for evaluation: _____

_____

C. Review and evaluation of other physical and/or mental, psychiatric, psychological examinations deemed necessary by the evaluator.

D. Review and comment on the material supplied by the Department of Health upon which the Commission bases its belief that an evaluation of the Respondent is appropriate.

E. Review of any other physical, mental, psychiatric, psychological, sociological or other relevant information provided by the Respondent.

F. Report should include a full and detailed discussion of the following:

1. Respondent's condition or diagnosis;
2. Conclusions and prognosis;
3. Any of the foregoing that you were not able to assess;
4. Recommendations regarding the need for ongoing care and treatment;
5. Professional opinion regarding Respondent's ability to practice nursing with reasonable skill and safety.

II. NCQAC members and staff may discuss the evaluation with the evaluators. The evaluation and written report are not privileged. Information may be shared between the staff and the evaluator. Respondent must sign an "Authorization to Release Confidential Records and Information" directed to the staff attorneys/Legal Servises Unit.

Washington State Nursing Commission
Approved Evaluators for Nurse Discipline Cases
Attachment Procedure A24.09

Name	Credentials	Areas of Specialization	Additional Relevant Experience	Approved to Conduct Evaluations in the Following Areas
Clark D. Ashworth 358 E Birch Ste 101 Colville WA 99114 (509) 684-8368	PhD Clinical Psychology Sex Offender Treatment Provider Certification; Diplomate and Board Certified: Forensic Examiner Disability Analyst	➢ Clinical Psychology ➢ Forensic evaluations ➢ Sexual deviancy	➢ Depression ➢ Anxiety disorders ➢ Health care providers	➢ Psychological evaluation ➢ Forensic evaluation ➢ Anxiety disorders ➢ Sexual deviancy and misconduct
Daniel Banken Tacoma WA 98467 (253) 475-6021	PhD Clinical Psychology	➢ Clinical Psychology ➢ Forensic evaluations ➢ Depression ➢ Anxiety disorders	➢ Relationship dysfunction	➢ Psychological evaluation ➢ Forensic evaluation ➢ Anxiety disorders
Allen Bostwick 1403 S Grand Blvd Suite 202N Spokane WA 99203 (509) 747-7700	PhD Clinical Psychology Board Certification: American Board of Professional Disability Consultants	➢ Clinical Psychology ➢ Clinical Neuropsychology ➢ Mental impairment	➢ Evaluation & treatment of chronic pain ➢ Traumatic brain injury ➢ Health care provider misconduct	➢ Psychological evaluation ➢ Neuropsychology ➢ Mental impairment ➢ Brain injury ➢ Chronic pain evaluation & treatment

Name	Credentials	Areas of Specialization	Additional Relevant Experience	Approved to Conduct Evaluations in the Following Areas
Alan R. Breen 1001 Broadway Suite 313 Seattle WA 98122 (206)860-0860	PhD, ABPN Clinical Psychology Neuropsychology Board Certification: American College of Professional Neuropsychology American Board Professional Neuropsychology	➢ Clinical Psychology ➢ Clinical Neuropsychology ➢ Geriatrics Neuropsychology ➢ Traumatic brain injury ➢ Cognitive Performance in Depression	➢ Attention Deficit Hyperactivity Disorder ➢ Intellectual performance in older adults ➢ Depression ➢ Substance abuse ➢ Female sexual disorders	➢ Psychological evaluation ➢ Neuropsychological evaluation ➢ Mental impairment ➢ Brain injury ➢ Substance abuse ➢ Female sexual disorders
Michael Comte 6314 19th Street West Suite 3 Tacoma WA 98466 (253) 564-3622	MSW Certified Sex Offender Treatment Provider	➢ Sexual deviancy & misconduct ➢ Risk assessment for vulnerable populations	➢ Health care provider sexual misconduct	➢ Sexual deviancy & misconduct ➢ Boundary violations ➢ Risk assessment for vulnerable populations
David Corey 5285 SW Meadows Road, Ste. 311 Lake Oswego OR 97035	Ph.D Clinical Psychology Board Certified in Forensic Psychology American Board of Professional Psychology	➢ Sexual deviancy & misconduct ➢ Depression/mental impairment ➢ Professional boundary violations	➢ Served on OR Psychological Assn Ethics Committee ➢ University instructor in ethics	➢ Psychological evaluation ➢ Sexual deviancy & misconduct ➢ Boundary violations
Christmas Covell 917 Pacific Avenue Suite 214 Tacoma WA 98402 (253)203-5284	Ph.D Clinical Psychology Sexual Offender Treatment Provider	➢ Clinical Psychology ➢ Psychosexual functioning	➢ Familiar with nursing practice ➢ Evaluated Health Professionals for DOH	➢ Clinical Psychology ➢ Psychosexual functioning

Name	Credentials	Areas of Specialization	Additional Relevant Experience	Approved to Conduct Evaluations in the Following Areas
Roland Dougherty 1701 Creekside Loop #108 Yakima WA 98902 (509) 965-1359	PhD Clinical Psychology	➢ Sexual deviancy & misconduct ➢ Boundary violations ➢ Clinical neuropsychology ➢ Forensic evaluations	➢ Health care providers ➢ Brain injuries ➢ Dementia ➢ Chronic pain	➢ Psychological evaluation ➢ Forensic evaluation ➢ Sexual deviancy & misconduct ➢ Boundary violations ➢ Brain injury ➢ Dementia ➢ Chronic pain
Brian Grant 1200 6th Avenue Suite 1800 Seattle WA 98101 (206) 447-3449	MD Psychiatry Board Certification: Forensic Psychiatry & Neurology (Psychiatry)	➢ Forensic Psychiatry ➢ Disability & impairment ➢ Mental status examination	➢ Somatoform pain disorders ➢ Chronic pain syndrome ➢ Injury claims ➢ Panic disorders ➢ Health care providers	➢ Psychiatric evaluation ➢ Psychiatric disabilities & impairment ➢ Chronic pain evaluation ➢ Injury claims ➢ Mental status evaluations ➢ Panic disorders
Constance Kehrer 1601 114th Ave SE Suite 180 Bellevue WA 98004 425-451-1134	PhD Clinical Psychology	➢ Clinical psychology ➢ Neuropsychology ➢ Emotional/behavioral disorders ➢ Psychological evaluation including intelligence, memory, attention, problem-solving ability	➢ Learning disabilities ➢ Attention Deficit & Hyperactivity Disorder (ADHD) ➢ Borderline personality disorders	➢ Psychological evaluation ➢ Neuropsychology ➢ Emotional disorders ➢ Behavior disorders ➢ Cognitive & behavioral testing & assessment ➢ Borderline personality disorders
Ronald M Klein 10 North Post Street	PhD Clinical Psychology	➢ Clinical psychology ➢ Neuropsychology	➢ Health care providers ➢ Medical expert for SSA	➢ Psychological evaluation ➢ Neuropsycholgy

Name	Credentials	Areas of Specialization	Additional Relevant Experience	Approved to Conduct Evaluations in the Following Areas
Ste 216 Spokane WA 99201-0705 (509) 838-1285		➢ Forensic evaluations		➢ Forensic evaluation
Yoriko Kozuki Psychosocial & Community Health University of WA School of Nursing Seattle WA 98195 (206)685-1219	Ph.D RN, ARNP Board Cerfication : American Nurses Credentialing Center American Psychoanalytic Assn	➢ Psychotherapy and medication management ➢ Psychiatric Nurse Practitioner	➢ Teaches mental health advanced practice students at UW ➢ Conducts evaluations for DSHS and other agencies	➢ Psychotherapy and medication management
Harry S. Levine Bellingham WA 98225 (360) 671-0383	MD Psychiatry Board Certification : Psychiatry and Neurology Forensic Psychiatry Convulsive Therapy	➢ General psychiatry ➢ Mental status evaluation ➢ Substance abuse ➢ Bipolar disorders ➢ Depression and anxiety	➢ Psychotropic medication management ➢ Post traumatic stress disorder	➢ Psychiatric evaluation ➢ Psychiatric disabilities and impairment ➢ Substance abuse ➢ Bipolar disorders ➢ Depression and anxiety

Name	Credentials	Areas of Specialization	Additional Relevant Experience	Approved to Conduct Evaluations in the Following Areas
Wendy B. Marlowe 901 Boren Ave Suite 610 Seattle WA 98104 (206) 623-5217	PhD Neurological Psychology Board Certifications : American Board of Clinical Neuropsychology ; Fellow & Diplomate, American Board of Medical Psychotherapists ; Diplomate, American Board of Professional Neuropsychology ; Diplomate in Clinical Neuropsychology, American Board of Professional Psychology	➢ Clinical Neuropsychology ➢ Intelligence ➢ Attention/Concentration ➢ Memory/ Learning evaluation ➢ Emotional Adjustment ➢ Motivation ➢ Sensory Perception	➢ Speech & Language pathology ➢ Attention Deficit Disorder Assessment	➢ Neuropsychological assessment ➢ Forensic Neuropsychology ➢ Neuropsychological rehabilitation ➢ Intelligence ➢ Memory/Learning evaluation ➢ Sensory perception ➢ Language assessment ➢ Traumatic Brain Injury ➢ Attention Deficit Hyperactivity Disorder ➢ Dementia ➢ Depression
W. Scott Mabee 905 West Riverside Avenue, Ste 610 Spokane WA 99201 (509) 742-3460	PhD Clinical Psychology	➢ Clinical Psychology ➢ Neuropsychology ➢ Behavioral medicine and evaluation ➢ Forensic evaluations	➢ Health care providers ➢ Medical expert witness	➢ Psychological evaluation ➢ Forensic evaluation

Name	Credentials	Areas of Specialization	Additional Relevant Experience	Approved to Conduct Evaluations in the Following Areas
Mark Mays 820 S McClellan St, Ste 414 Spokane WA 99204 (509) 624-4800	PhD JD	➢ Clinical Psychology ➢ Attorney at Law	➢ Consultant for DSHS ➢ Faculty at multiple universities ➢ Health care providers ➢ Alcohol and substance abuse treatment ➢ Previous Psychology Board member	➢ Psychological evaluation ➢ Substance abuse
Loren W. McCollom Tacoma WA 98445 (253) 537-2574	PhD Counseling Psychology	➢ General psychology ➢ Counseling/therapy ➢ Adult mood, affective or adjustment disorders ➢ Forensic Psychology ➢ Health care psychology	➢ Psycho diagnostics and psychology for children, adolescents and their families	➢ Psychological evaluation ➢ Depression ➢ Forensic psychology
Henry Montgomery 905 W Riverside Avenue, Ste 501 Spokane WA 99201 509-744-0778	Ph.D. Clinical Psychcology ;	➢ Substance abuse disorders ➢ Forensic evaluations ➢ Problem gambling	➢ Expert witness in WA	➢ Forensic evaluations ➢ Substance abuse
Richard Packard 321 High School Road, Suite 218 Bainbridge Island, WA 98110 (206)321-1017	Ph.D Sexual Offender Treatment Provider	➢ Mental health/mental disorders ➢ Sexual deviancy/sexual misconduct ➢ Forensic assessments	➢ Evaluator for Dental Commission and Psychology Assn	➢ Mental health/mental disorders ➢ Sexual deviancy/sexual misconduct ➢ Forensic assessments

Name	Credentials	Areas of Specialization	Additional Relevant Experience	Approved to Conduct Evaluations in the Following Areas
Leslie Rawlings 1001 Broadway Suite 315 Seattle WA 98122 (206) 323-0905	PhD Psychology Certification: Sex Offender Treatment Provider	➢ Sex Offender evaluation & treatment ➢ Boundary violations ➢ Prediction of violent behaviors	➢ Risk assessment for vulnerable populations ➢ Health care providers	➢ Psychological Evaluation ➢ Sexual deviancy & misconduct ➢ Risk assessment for vulnerable populations
Richard L. Schneider 3609 S 19th Street Tacoma WA 98405 (253) 752-6056	MD Psychiatry Board Certification: Diplomate , American Board of Psychiatry & Neorology in Child & Adolescent Psychiatry; Diplomate, American Board of Psychiatry & Neurology in Psychiatry	➢ Child, Adolescent & Adult Psychiatry ➢ Neuropsychiatry		➢ Psychiatric Evaluation ➢ Neuropsychiatric Evaluation
Lawrence Smith 800 5th Avenue Suite 4100 Seattle WA 98104 (206)447-1404	Ph.D Clinical Psychology	➢ Clinical psychology ➢ Behavioral medicine/pain management ➢ Depression/mental impairment ➢ Neuropsychological impairment – brain injuries/dementia ➢ Sexual deviancy & misconduct ➢ Ethics and professional boundary violations	➢ Works with and supervises nurses ➢ Familiar with WAC 246-840 and the American Nurses Assn Code of Ethics	➢ Clinical psychology ➢ Behavioral medicine/pain management ➢ Depression/mental impairment ➢ Neuropsychological impairment – brain injuries/dementia ➢ Sexual deviancy & misconduct ➢ Ethics and professional boundary violations

Name	Credentials	Areas of Specialization	Additional Relevant Experience	Approved to Conduct Evaluations in the Following Areas
Paul Spizman PO Box 64972 Tacoma WA 98464	Ph.D Clinical Psychology Certified Sex Offender Treatment Provider	➢ Clinical psychology ➢ Sexual offender evaluations	➢ Workplace fitness for duty evaluations	➢ Clinical psychology ➢ Sexual deviancy & misconduct
David Stoker 1550 South Pioneer Way, Suite 370 Moses Lake WA 98837 (509)793-9769	Ph.D Clinical Psychology	➢ Clinical psychology ➢ Substance abuse	➢ Evaluator for Labor & Industries	➢ Clinical psychology ➢ Substance abuse
Angelique Tindall 1120 N Pines Ste C Spokane WA 99206 (509) 768-4248	PhD Clinical Psychology	➢ Clinical Neuropsychology ➢ Rehabilitation and Health Psychology	Health care providers	➢ Psychiatric Evaluation ➢ Neuropsychiatric Evaluation
Allen Traywick 1008 Yakima Ave Suite 202 Tacoma WA 98405 (253) 752-1233	PhD Counseling & Psychology	➢ Sexual deviancy & misconduct ➢ Forensic Psychology	➢ Risk assessment for vulnerable populations ➢ Health care providers	➢ Psychological Evaluation ➢ Sexual deviancy & misconduct ➢ Boundary violations ➢ Risk assessment for vulnerable populations
J. Robert Wheeler Alderwood Business Campus 19105 36th Ave West Lynnwood WA 98036 (425) 771-0970	PhD Counseling Psychology Sex Offender Treatment Provider Certification	➢ Forensic Psychology ➢ Sexual deviancy & misconduct	➢ Victims of abuse ➢ Health care providers	➢ Psychological Evaluation ➢ Forensic Psychology ➢ Sexual deviancy & misconduct ➢ Boundary violations ➢ Victims of abuse

Name	Credentials	Areas of Specialization	Additional Relevant Experience	Approved to Conduct Evaluations in the Following Areas
Jennifer Wheeler 1370 Stewart St Suite 107 Seattle WA 98109 (206)484-2194	Ph.D Licensed Psychologist Sexual Offender Treatment Provider	➢ Clinical Psychology ➢ Forensic Psychology ➢ Sexual deviancy & misconduct	➢ Evaluator for other health professions	➢ Clinical Psychology ➢ Forensic Psychology ➢ Sexual deviancy & misconduct
Mark B. Whitehill 3815 100th St SW Ste 2-B Lakewood WA 98499 (253) 984-7686	Ph.D Sex Offender Treatment Provider Certification	➢ Clinical Psychology ➢ Forensic Psychology ➢ Sexual deviancy & misconduct		➢ Psychological Evaluation ➢ Forensic Psychology ➢ Sexual deviancy & misconduct ➢ Boundary violations
Alan Wilensky 325 Ninth Ave Box 359745 Seattle WA 98104 (206) 744-4409	Ph.D Certified in Neurology	➢ Epilepsy		➢ Epilepsy

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
Procedure

Title:	Using Commission Panels for Decision Making	**Number:**	A25.04
Reference:	RCW 18.130.050		
Effective Date:	September 13, 2013		
Supersedes:	July 1, 2005; August 24, 2000; August 1, 2012		
Approved:			
	Chair, **Nursing Care Quality Assurance Commission**		

PURPOSE:

The Nursing Care Quality Assurance Commission (NCQAC) uses three member panels to determine the disposition of cases for charging and closure. The NCQAC chair assigns members to the panels at each July meeting. The panels conduct their meetings in person, by telephone or electronic meetings. Members of case disposition panels may sit on final hearing panels. Panels promote consistency in the level of charging and discipline for similar types of violations. Panel members orient and train new NCQAC members about the disciplinary process by participating on a panel before they begin reviewing cases.

PROCEDURE:

Panel Membership

The NCQAC chair assigns members to a case disposition (charging) panel. The NCQAC chair assigns a chair of each panel. The panel chair convenes the panel to meet the members' caseload requirements and disciplinary timelines. The chair of the panel will be an active member of the NCQAC. A staff attorney attends all case disposition panel meetings for consultation.

The panels promptly address all Priority A cases. A NCQAC member may present a Priority A case to any of the case disposition panels or CMT authorization panel to expedite the decision-making process.

Pro-tem members may be included as panel members as their individual caseload requires. If a pro-tem member is not a regular panel member, they may be referred to a panel by staff for case review.

Meetings

Panels are set for a specific day and time each month. Any changes to the scheduled meetings are announced by the chair. Meetings require three members to be present. The collaborative effect of the

group, as opposed to separate, individual exposures to the evidence, is essential for consistency and uniformity. Mail or e-mail decisions will not be allowed.

Timelines

Timelines allow up to 45 days for the RCM to review the file and present the case to the panel.

Case Presentation

Only the Reviewing Commission Member (RCM) accesses the investigation file. The RCM reviews the allegations and the evidence in the investigative file that either support or refute the allegations, including but not limited to medical records, facility/employer documents, pharmacy audits, police/court reports, witness statements and interviews. The RCM presents their case to the panel for discussion. Cases will be referred to by case number only. To protect the confidentiality of the licensee, names and other identifying information will not be used.

Decision

Disposition options include case closure, informal action – STID, formal Action - SOC, Summary Suspension.
Following discussion, the panel reaches consensus regarding the disposition of the case and proposed conditions for an agreed order.

If the RCM contemplates a summary suspension or if there are legal concerns or questions, the RCM contacts an AAG or staff attorney in advance of the meeting.

If the AAG or staff attorney cannot support the decision of the panel, they contact the RCM. After consulting with the RCM, the RCM may modify the decision. The RCM confirms the new decision at the next meeting of the panel.

Documentation

The RCM completes work sheets for each case to document the meeting and the members present. The RCM saves the worksheets in their Secure File Transfer (SFT) file. If they are not able to access SFT, worksheets may be sent to the NCQAC office via email or postal service,

Revised 08/01/2012
Revised 07/01/2005

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
POLICY

Title:	Drafting and Interpreting Disciplinary Orders	**Number:**	A28.05
Reference:	RCW 18.130.180 (9); RCW 18.130.160		
Contact:	Paula R. Meyer, Executive Director		
Effective Date:	September 13, 2013		
Supersedes:	July 1, 2005; January 9, 2004; March 21, 2003; August 1, 2012		
Approved:			
	Chair **Washington State Nursing Care Quality Assurance Commission**		

PURPOSE: To assure uniformity and consistency in the drafting and interpretation of terms in Disciplinary Orders, the Nursing Care Quality Assurance Commission (NCQAC) adopted the following.

Drafting and Interpreting Disciplinary Orders:

A. Setting Deadlines
All Orders should include a specific deadline for completion by the respondent of each term. Only the Reviewing Commission Member (RCM) may extend a deadline.

B. Educational Classes
Respondent must seek approval by the RCM for all educational classes and coursework prior to attendance. Failure by the respondent to obtain pre-approval of the course is considered failure to comply and may subject the respondent to additional disciplinary action.

C. Research Papers and Essays
The Order defines the topic(s) and the length of the research paper or essay (number of words, generally 1000 words per topic), which must be typewritten and must explicitly address the topic assigned.

Research papers and essays must be submitted to the RCM for approval. At the discretion of the RCM, Respondents may be offered one opportunity to revise and re-submit the document(s).
Revised documents will be due to the compliance officer no more than 30 days after the request for revision is granted.

E. Supervised Practice by a Worksite Monitor
All Worksite Monitors must be pre-approved by the RCM. Qualifications to serve as a Worksite Monitor: Registered Nurse with an unrestricted license to practice in Washington, no history of discipline in any state[1], and five (5) years of experience as an RN. If the Respondent is an LPN, the Worksite Monitor may be an LPN, at the discretion of the RCM.

F. When supervised practice is required following an educational class, (*e.g.*, Medication Administration) only hours following completion of the class are credited.

G. Fines
Respondents may be subject to a fine or cost recovery up to $1000 for each violation.

Revised 08/01/2012
Revised 07/01/2005
Revised 01/09/2004

[1] NURSYS will be queried.

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
POLICY

Title:	Lists and Labels Recognition Criteria	**Number:**	A29.03
Reference:	RCW 42.17.260 (9)		
Contact:	Paula Meyer, (360) 236-4713		
Effective Date:	September 13, 2013		
Supersedes:	September 13, 2002; November 16, 2007; July 11, 2008; March 13, 2009; October 19, 2009		
Approved:			
	Chair **Washington State Nursing Care Quality Assurance Commissi**on		

PURPOSE:

Pursuant to RCW 42.56.070(9) staff may give lists of individual nurses, including addresses, to professional associations and educational organizations recognized by the Nursing Care Quality Assurance Commission (NCQAC). An organization or association may be denied recognition by the NCQAC only for good cause after a hearing pursuant the Administrative Procedure Act, RCW 34.05.

PROCEDURE:

This procedure defines criteria for staff to evaluate applications for lists and labels by professional associations and educational organizations. Such associations or organizations meeting these criteria may be given lists of individual nurses, including addresses, upon payment of an appropriate fee as allowed by RCW 42.56.070(9).
If the applicant does not meet these criteria, a hearing before the NCQAC may be scheduled at the request of the organization or association's request.

Educational Organization

An accredited or approved institution or entity preparing professionals for initial licensure in a health care field or providing continuing education for health care professionals.

Professional Association

A group of individuals or entities organized to:

- represent the interest of a profession or professions;
- develop criteria or standards for competent practice; or,

- advance causes seen as important to its members, which will improve quality of care rendered to the public.

Revised: 07/19/11

NAME OF RECOGNIZED ASSOCIATION FOR PURPOSES OF LISTS/LABELS REQUESTS	DATE OF RECOGNITION
~~**1.** SEIU (Union)~~	9/17/02 REMOVED 7/11/08 AT COMMISSION MEETING
2. Council of Nurse Educators of Washington State (CNEWS)	9/17/02
3. Washington State Nurses Association (WSNA)	9/17/02
4. Washington Association of Nurse Anesthetists (WANA)	9/17/02
5. School Nurses Association of Washington (SNOW)	9/17/02
6. Association of Operating Room Nurses (AORN)	9/17/02
7. American College of Nurse Midwives	9/17/02
8. Midwives Association of Washington State (MAWS)	9/17/02
9. Washington Association of Perioperative Nurses (WAPN)	9/17/02
10. Washington State Hospital Association (WSHA)	9/17/02
11. Home Care Association of Washington (HCAW)	9/17/02
12. ARNP United	9/17/02
13. Association of Advanced Practice Psychology Nurses (AAPPA)	9/17/02
14. Rural Hospital Associations	9/17/02
15. Washington Hospice and Palliative Care Association	9/17/02
16. All approved schools of nursing as listed in the NCLEX Candidate bulletin for U.S. or U.S. territories jurisdictions	9/17/02
17. King County Nurses Association	8/27/03
18. Western University of Health Sciences, College of Graduate Nursing, 309 East Second Street, Pomona, CA 91766-1854	12/19/03
19. American Red Cross	2/20/04
20. RL University (California)	4/23/04
21. American Academy of Nurse Practitioners, PO Box 12846, Austin, TX 78711 (mjgoolsby@aanp.org)	7/16/04
22. Institute for Natural Resources , 2354 Stanwell Drive, Concord, CA 94250 (925) 609-2820	8/20/04
23. Fred Hutchinson Cancer Research Center	12/2/04
24. National Council of State Boards of Nursing (NCSBN)	3/1/05
25. Old Dominion University	8/15/05
26. Washington Center for Nursing – Seattle – Non profit organization	4/25/06
27. American Nurses Association (ANA)	8/10/06
28. West Sound Advanced Practice Association, 2916 NW Bucklin Hill Road, Suite 232, Silverdale, WA 98383 WSAPA@msn.com	8/10/06
29. Publishing Concepts Inc. (PCI) Virginia Robertson, 14109 Taylor Loop Road, Littlerock, AR 72223 vrobertson@pcipublishing.com	9/20/06
30. University of Phoenix, 3380 146th Place SE, Suite 200, Bellevue, WA 98007 1-800-260-6977	3/12/07

meina.cheng@phoenix.edu	
31. Cecil G. Sheps Center for Health Services Research (Branch of University of North Carolina at Chapel Hill) Alan R. Ellis, MSW, Research Associate and Fellow, 725 MLK Boulevard, CB7590, Chapel Hill, NC27599-7590	7/9/07
32. Brooks College of Health (ARNP), University of florida, J. Brooks Brown Hall Bldg 39/3031, 4567 St. Johns Bluff Road, South, Jacksonville, FL 32224-2673 (904)-620-2810 Lucy Trice, Ph.D, ARNP, BC	7/18/07
33. Maya Bhat, MPH, Infectious Disease Epidemiologist, Clark County Public Health, PO Box 9825, Vancouver, WA 98666-8825, (360) 397-8000 ext 7257	9/12/07 One time approval
34. Steve Meyer, President, CEO, Fedelta Home Care, Washington Case Manager Association, Home Care & Hospice & National Private Duty Organization, 110 – 110th Avenue NE, Suite 680, Bellevue, WA 98004 (425) 454-4548	9/13/07
35. Gritman Medical Center, Brian Frei, Clinical Educator, Brian.Frei@gritman.org (208) 883-2226	9/20/07
36. Fedelta Home Care, Steve Meyer, 110 110th Avenue NE, Suite 680, Bellevue, WA 98004, (425) 454-4548 or www.fedeltahomecare.com	10/19/07
37. University of Washington Educational Outreach, Amanda Snypp, UWEO Marketing Assistant, 5025 25th Avenue NE, Suite 204, Seattle, WA 98105, (206) 685-6521, asnypp@extn.washington.edu	11/16/07 Full Commission approval
38. Seattle STD/HIV Prevention Training Center University of Washington, 901 Boren Avenue, Suite 1100, Seattle, WA 98104, (206) 685-9846, ammeegan@u.washington.edu	11/16/07 Full Commission approval
39. PESI, LLC, Tommy Bennett, Research and Development, PO Box 1000, Eau Claire, WI 54702, (715) 833-5271 or tbennett@pesi.com	12/7/07
40. National Association of Pediatric Nurse Practitioners (NAPNAP) Nancy Nelson, 3322 Madrona Beach Road NW, Olympia, WA 98502 (360) 866-0854 http://wwww.nurse.org/wa/napnap/	12/13/07
~~41. SEIU Healthcare 775NW, 33615 First Way South, Suite A, Federal Way, WA 98003. Misha Werschkul, (253) 815-3740~~	4/15/08 REMOVED 7/11/08 AT COMMISSION MEETING
42. National Organization of Nurse Practitioners Faculties, Louise Kaplan, Ph.D., ARNP, 14204 NE Salmon Creek Avenue, Vancouver, WA 98686, (360) 546-9618	5/12/08
43. The Research Foundation, 44 Pierrepont Avenue, Potsdam, NY 13676, Laurel Sharmer, Ph.D, MPH, CHES, 315 268-0836	6/26/08
44. Medical Simulation Corporation, Debbie Fimple, 4600 south Ulster Street, Suite 450, Denver, CO 80237 (303) 483-2800	7/08/08
45. Oregon Nurses Association, Mary Schwartz or Kathy Gannett, 18765 SW Boones Ferry Road, Suite 200, Tualatin, OR 97082 (503) 293-0011	07/09/08
46. Washington State Student Nurses	7/11/08 Full Commission approval
47. Cross Country Education, 9020 Overlook Boulevard, Suite 140,	8/22/08

Brentwood, TN 37027 1 800- 397-0180 Melissa Harding	
48. Medenet, Erich Kaiser 5930 South 58th Street, Suite O, Lincoln, NE 68516 (402) 261-6826 (Educational)	8/22/08
49. West Sound Advanced Practice Association, Benjamin Miller, 2916 NW Bucklin Hill road #232, Silverdale, WA 98311 (406) 550-9012 (Educational)	9/24/08
50. Research Foundation of the State University of New York, Dr. Laurel Sharmer, 44 Pierrepont Avenue, Potsdam, NY 13676 (315) 268-0836	10/1/08
51. American Red Cross, Mount Rainier Chapter, Walter A. Huber, 1235 south Tacoma Way, Tacoma, WA 98409 (253) 759-2639	1/5/09
52. Health Education Network, LLC, DBA Health Ed. Pat Meixner, 304 Gray Street, Suite 201, Euclaire, WI 54701, (715) 532-9519	1/28/09
53 Tobacco Prevention Resource Center, Deb Drandoff, 2500 NE 65th Avenue, Vancouver, WA 98661 (360) 750-7500 x 303	2/2/09
54. Oregon Health & Science University, Kelsey Cearley, 3181 SW Sam Jackson Park Road, Portland, OR 97239 (503) 494-1475	2/11/09
55. National Association of Nurse Practitioner Faculties, Kitty Werner 9202) 289-8044 or Louise Kaplan (360) 956-1164, 1522 K Street, Washington, DC 20005	2/18/09
56. Eastern Washington University, David Bunting, Ph.D., Department of Economics/PAT300, Cheney, WA 99004 (509) 359-7947	4/22/09
57. Texas Nurses Association, Kristine L. Winning, 7600 Burnet road, Suite 440, Austin, TX 78757, (512) 467-0615 ext 190	6/26/09
58. Pacific Lutheran University, Terry Bennett, 1010 south 122nd Street, Tacoma, WA 98447, (253)-535-7683	7/9/09
59. The Wellness Institute, David Hartman, 3716 274th Avenue SE, Issaquah, WA 98029, (425) 391-9716	10/9/09
60. Legacy Good Samaritan Hospital, Cancer Services, Ileana Craig, 1015 NW 22nd Avenue, Wilcox 106, Portland, OR 97210 (503) 413-7766	10/9/09
61. The Rx Consultant, Tia Daniel, 628 D Street, Martinez, CA 94553	10/9/09
62. SEIU 1199 NW, Diane Sosne, RN, MN, President, 15 South Grady Way, Suite 200, Renton, WA 98057, 1-800-422-8934, fax (425) 917-9707	10/19/09 Added at special commission meeting
63. SEIU 775 NW, David Rolf, President, 33615 First Way South, Suite A, Federal Way, WA 98003, 1-866-371-3200, FAX (253) 815-3701	10/19/09 Added at special commission meeting
64. Transformative Group dba Association for Humanistic Psychology, Susan Burns, MA, LMHC, 2370 130th Avenue NE, Suite 106, Bellevue, WA 98005, (415) 435-1604 or ahpoffice@aol.com	12/3/09 Educational
65. Boise State University, Lori Werth, 1910 University Drive, Boise, ID 83725-1840, (208) 426-4632	12/3/09 Educational
66. Mt. Baker Nurse Practitioner Association, Christine Anderson, 302 36th Street, Bellingham, WA 98225, (360) 815-7043	11/4/09 Association
67. Wu Hsing Tao School, Kristin Bach, 4000NE41 St, Bldg D, Seattle, WA 98105 www.wuhsing.org	12/7/09 Educational
68. Nurse Practitioner Group of Spokane, Marylynn Bernard, 1118 W 28 St, Spokane, WA 99203 509-624-2290	12/7/09 Association
69. Bastyr University, Sue Russell, 14500 Juanita Dr NE, Kenmore, WA 98028 425-787-2697	12/10/09 Educational
70. Seattle University, College of Nursing, Martha H. Goedert, 901 12th Ave Garrant #404, Seattle WA 98122	2/16/10 Educational
71. Western Pain Society, Jennifer M Wagner, 65W-1 Division Ave #237, Eugene OR 97404	5/3/10 Educational

DENIAL OF NURSING ORGANIZATIONS OR EDUCATIONAL INSTITUTIONS

Date received	Name/Address	Educational or Professional	Denial process
3/27/08	Dale Anderson, President, Right At Home, 412B Bowes Drive, Tacoma, WA 98466	Professional	Denial letter 4/10/08 Appeal received by fax 7/25/08 to ASU
?	Misha Werschkul, SEIU Healthcare 775NW, 33615 First Way South, Suite A, Federal Way, WA 98003	Professional	Denial Letter 4/17/08 sent from DOH. 7/11/08 NCQAC voted to remove from approved list although there was no pending nursing request . Denial letter sent 7/15/08 Copy of file to ASU 8/20/08 for appeal hearing
5/07/08	JoAnn DelProposto, Kelly Healthcare Resources	Professional	Denial Letter 5/27/08
5/16/08	Gina Redden, Fastaff Travel Nursing, 6501 South Fiddler's Green Circle, Suite 200, Greenwood village, CO 80111	Professional	Denial Letter 5/27/08
5/29/08	Jack Blackburn, 5762 27th Avenue NE, Seattle, WA 98105	Educational	Denial Letter 6/30/08
5/29/08	Doug Minotti, Integrated Pharma Technologies	Professional	Denial Letter 6/30/08
7/14/08	Pauline McDaniel, RN, DNS, Liberty County Place, 917 south Scheuber Road, Centralia, WA 98531	Professional	Denial Letter 7/28/08
8/27/08	Ann L. Shepherd, RN, BSN, Law Offices of Julianne Kocer, P.S., 301 NE 100th Street, Suite 310, Seattle, WA 98125	Educational	Denial ltr 8/27/08
8/16/08	Jim Kammerer Department of L & I PO Box 44322 Olympia, WA 98504-4322	Professional	Denial ltr 10/17/08
6/30/08	Edward Via Virginia College of Osteopathic Medicine 2265 Kraft Drive Blacksburg, VA 24060	Educational	Denial ltr 10/17/08
10/10/08	Joe Cattrell, President	Professional	Denial ltr 10/17/08

	AAA Medical Staffing 415 SE 117th Ave, Suite 102 Vancouver, WA 98683		
9/16/08	Lisa Engvall, Librarian Research & Data Services – Library Services Department of L & I PO Box 44606 Olympia, WA 98504-4606	Professional	Denial ltr 10/17/08
9/27/08	Barbra Brown Dare to Care Enterprises 1233 South Stevens Street Tacoma, WA 98405	Professional	Denial ltr 10/17/08
2/11/09	Joanne Rogovoy March of Dimes Greater Oregon Chapter 1220 SW Morrison #510 Portland, OR 97205	Educational	Denial ltr 2/12/09
2/6/09	Joshua Kaplan-Lyman Healthcare United 3536 SE 26th Avenue Portland, OR 97202	Professional	Denial ltr 2/24/09
3/25/09	Kelli Pearson, D.C. Full Life Consulting South 2119 Tekoa Spokane, WA 99203	Educational	Denial ltr 3/30/09
3/09/09	Labor and Industries, Ron Burford, 7273 Linderson Way SW, Tumwater, WA 98501-4005	Professional	Denial ltr 4/9/09
4/6/09	Karen Moffett, Sound Family Medicine, 3908 10th Street SE, Puyallup, WA 98374	Professional	Denial ltr 4/30/09
2/24/09	Karissa Patin, LHC Group, 420 West Pinhook Road, Lafayette, LA 70503	Professional	Denial Ltr 4/30/09
2/18/09	Casey Rukeyser, SEIU Healthcare District 1199 NW, 15 South Grady Way, Suite 15, Renton, WA 98055	Professional	Denial ltr 8/11/09 Needed additional information
6/16/09	Melody Hopkins, Cegedim Dendrite, 1025 Boulders parkway, Suite 405, Richmond, VA 23225	Professional	Denial ltr 8/11/09 Needed additional information
12/12/08	Kristi Wagoner, Kootenai	Professional	Denial ltr 8/11/09

	Health, 2003 Lincoln Way, Coeur d'Alene, ID 83814		Needed additional information
10/25/08	Sam Sharma, Protouch Staffing, 17822 Davenport road, Suite A, Dallas, TX 75252	Professional	Denial ltr 8/11/09 Needed additional information
10/13/08	Erin Murray, 2101 Ken Pratt Boulevard, Suite 200, Longmont, CO 80503	Not identified	Denial ltr 8/11/09 Needed additional information
10/13/09	Verisys/GMS, Jody Brandow, 10653 South river Front Parkway, Suite 140, South Jordan, UT 84095	Professional	Denied 10/19/09. Denial letter to come from DOH for all professions 10/27/09
10/20/09	StaffLink, Monica White, 14900 Interurban Avenue South, Suite 277, Tukwila, WA 98168	Professional	Denial letter 11/3/09
10/29/09	Gentiva Health Services	Professional	Denial ltr 12/4/09 Needed additional info
10/26/09	Medcor, Inc.	Professional	Denial ltr 12/4/09 Needed additional info
8/27/09	Fastaff Travel Nursing	Professional	Denial ltr 12/4/09 Needed additional info
6/10/09	Trinity Health Care Staffing Group	Unknown	Denial ltr 12/4/09 Needed additional info

Procedures for List and Label Requests

All requests to be added to the recognized list for purposes of lists/labels requests should be forwarded either to the Executive Director or Deputy Executive Director of Unit #6.

1. All requests for lists and labels should be forwarded to the Manager for the Public Disclosure Resource Center (PDRC).

Adding organizations to the recognized list:

1. The Executive Director or Deputy Executive Director review the request against the Nursing Commission's approved criteria. If the request meets the criteria the name of the organization is added to this list and a copy is sent to the Public Disclosure Resource Center, and the s:drive is updated.

2. If the organization does not meet the criteria the Executive Director or Deputy Executive Director writes a Notice of Intent to Deny to the organization explaining their rights of appeal. A copy of the letter will be sent to the Public Disclosure Resource Center.

3. If the organization files an appeal with the Adjudicative Service Unit a hearing will be arranged with the chair or his or her designee. The hearing will consist of a paper review of the materials supplied by the Department of Health and the appealing organization. A face-to-face hearing is an option for the chair or his or her designee.

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE

Title:	Early Remediation Program	**Number:**	A34.04
Reference:	RCW 18.130.050, -090, -172		
Contact:	Mary Dale, Disciplinary Manager		
Effective Date:	September 13, 2013		
Supersedes:	July 19, 2011; September 11, 2009, September 21, 2012		
Approved:			
	Chair **Washington State Nursing Care Quality Assurance Commission**		

PURPOSE STATEMENT:

The Early Remediation Program entails developing an Action Plan seeking to remedy apparent clinical deficiencies during the investigation phase of substandard care complaints involving low to moderate risk of harm.

PROCEDURE

I. When the Nursing Care Quality Assurance Commission (NCQAC) receives a report of substandard nursing practice, staff follow the intake procedure for initiation of a case file, review for serious patient safety issues, etc. If serious patient safety issues are ruled out, the case proceeds to the next regularly scheduled Case Management Team (CMT). The CMT preliminarily reviews the report and makes one of three decisions:

A. Close the matter without action (See Procedure A06);

B. Authorize the case be opened for full investigation; or

C. Authorize the case for investigation and identify the case as a possible candidate for the Early Remediation (ER) Program.

II. The CMT determine if a nurse is eligible for the ER Program using the following criteria:

A. The nurse's continued practice does not pose a threat to patient safety.

B. The alleged conduct involves clinical practice deficiency issue(s) that could be corrected through additional education, practice monitoring, practicum participation, and/or other assignments as deemed appropriate by the ER panel within a limited period of time, not to exceed 6 months.

C. The alleged conduct resulted in no or minor harm.

D. The case involves issues of substandard care only and does not involve willful misconduct or other unprofessional conduct.

E. The nurse is willing and able to participate.

F. If the nurse is employed, the employer, facility, or other entity is willing and able to participate.

III. In a case identified as a potential candidate for the ER Program, an assigned Nursing Consultant Institutional (NCI) conducts a preliminary investigation to confirm substantiation of the alleged substandard practice. Such a preliminary investigation includes, at a minimum, interviews of the Complainant, Respondent and any other key witnesses, as well as obtaining additional documentation.

IV. NCQAC staff presents the preliminary results to an ER Team consisting of three NCQAC members and supporting staff. Supporting staff consists of the Chief Investigator, Staff Attorney, ER Monitor, Disciplinary Manager and/or Case Manager. The ER Panel is the three NCQAC members only.

A. If the preliminary investigation results demonstrate the allegation(s) are unsubstantiated, lack jurisdiction, or are below threshold the case is closed (see Procedure A22).

B. If the preliminary investigation results demonstrate the case meets the criteria in Section II, the ER Team determines the appropriate terms for a suggested Action Plan to remedy the identified deficiencies in nursing practice. (See attached Action Plan form).

C. If the preliminary investigation results demonstrate the case is no longer appropriate for the ER Program, the ER Panel authorizes the file for full investigation.

V. NCQAC staff sends the suggested Action Plan to the Respondent, and if appropriate, Respondent's employer.

A. If the participant accepts the suggested Action Plan, the Action Plan is monitored by designated staff.

B. If the participant declines the Action Plan, or if criteria in section II.E and/or II.F are not met, the ER Panel returns the case for full investigation.

VI. The Action Plan requirements will be completed within 6 months from the date the investigation was opened. NCQAC staff presents the case to the ER Team for a decision. The ER Team reviews a summary report including:

- the initial complaint,
- the preliminary investigation report, and
- the Action Plan results.

The ER Panel considers the timely and successful completion of an Action Plan as grounds to close the matter without action as below threshold (i.e. risk minimal, not likely to reoccur).

If the Action Plan results demonstrate failure to meet the Action Plan requirements, NCQAC staff send the participant written notice. If the participant believes they have met the requirements, they may provide a statement to the ER Team. The ER Panel will review information from the NCI, as well as any statement submitted by the participant before making a final decision.

Criteria to use when returning case for full investigation include, but are not limited to:

A. The nurse was unable to substantially complete the Action Plan or demonstrate rehabilitation.

B. The nurse was unable to complete the Action Plan within the time frame outlined in the Action Plan.

C. Discovery of additional facts indicate the alleged conduct resulted in significant patient harm or was more serious than originally alleged.

D. Allegations of additional practice deficiencies or unprofessional conduct.

VII. If the nurse participated in the Action Plan but failed to successfully complete the Action Plan within six months, they may be eventually charged with unprofessional conduct. In determining appropriate sanctions, NCQAC will consider participation in the Action Plan a mitigating factor under WAC 246-16-890(3)(c)(voluntary remedial action); (4)(d)(potential for successful rehabilitation); and/or (4)(e)(present competence to practice).

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
POLICY

Title:	Safe to Practice	**Number** A40.02
Reference:		
Contact:	Discipline Manager	
Effective Date:	September 13, 2013	
Supersedes:	May 13, 2011	
Approved:		
	Chair **Washington State Nursing Care Quality Assurance Commission**	

PURPOSE:

This guideline addresses "safe to practice" concerns expressed by nurses and employers. Concerns expressed include, but are not limited to practicing while taking prescribed medications, including pain medications; refusing assignments to work overtime or extra shifts when feeling unsafe to practice; and retiring from practice when reaching a certain chronological age. This guideline provides direction to assist nurses and employers in addressing these concerns.

POLICY

One essential element of safe nursing practice is a nurse's functional ability. It is the competence and reliability with which a nurse is able to practice at any given time that determines the functional ability of the nurse.

The Nursing Care Quality Assurance Commission (NCQAC) is aware that nurses experience situations on occasion that may compromise their ability to safely practice for either a short or long period of time. Some of these situations involve personal or job-related stress, sleep deprivation, the normal effects of aging, and episodic or persistent health conditions, some of which may require pain management or the use of maintenance-level prescribed medication. The list is not all inclusive of every possible event that may limit a nurse's functional ability.

The nurse's ability to function safely and effectively determines whether a nurse should continue active nursing practice. The assessment of functional ability is an individualized process that does not lend itself to application of a set format based on select elements. On the contrary,

assessment of functional ability requires active consideration of all relevant factors, such as diagnosis, prescribed treatment and situational events, as well as an evaluation of the impact of those factors on the individual.

Constant evaluation of one's ability to safely and competently practice nursing is the responsibility of each individual nurse. Licensed nurses are accountable for assuring that their actions and behaviors meet all applicable standards at all times. This requires constant awareness of the demands of the job and a continual process of evaluation and assessment in order to make sure that the nurse is fit to practice and competent to safely perform those functions that fall within the defined scope of nursing practice and for which the nurse has accepted responsibility.

Employers are required to report nurses that are unsafe in practice to the NCQAC and must protect patients from harm.

The NCQAC investigates and evaluates violations of safe practice. In some instances, it may be necessary for the NCQAC to require objective physical and or functional assessment of the nurse using reliable psychometric instruments and methods administered by qualified licensed professionals. For example, even though an individual nurse might perceive that he is capable of safe practice, a neuropsychiatric assessment, done at the NCQAC request, may indicate functional impairment.

Nurses who practice while not fit to do so may be subject to discipline. Sanctions may include action by the NCQAC including, among others, remedial measures, monitored practice, license suspension or revocation.

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE

Title:	Investigative Mental and/or Physical Examinations	**Number:**	A41.02
Reference:	RCW 18.130.050, 18.130.095, 18.130.170, WAC 246-11-080 and 246-10-109		
Contact:	Mary Dale, Discipline Manager		
Effective Date:	September 13, 2013		
Supersedes:	HPQA 232, 1/11/2005; August 2, 2012		
Approved:			
	Chair **Washington State Nursing Care Quality Assurance Commission**		

PURPOSE: This procedure establishes a uniform process to order investigative mental and/or physical examinations consistent with the requirements of RCW 18.130.170.

PROCEDURE:

1. A team assembled by the discipline manager considers the need to request an investigative mental and/or physical examination.

   A. The team includes:
   - A Nursing Care Quality Assurance Commission (NCQAC) case disposition panel and a staff attorney.

   B. The team may include the:
   - Executive director, discipline manager and/or an
   - AAG prosecutor.

2. If an examination seems appropriate, the file is given to the Office of Legal Services (OLS).

   A. OLS staff prepare the documents in support of the examination, including the Notice of Intent to Order Investigative Mental and/or Physical Examination and the Proposed Order for Investigative Mental and/or Physical Examination. These documents must include the elements specified in RCW 18.130.170(2)(a).

   B. The AAG prosecutor signs the Notice of Intent.

3. OLS serves the documents on the Respondent and files them with the Adjudicative Clerk Office (ACO).

4. ACO schedules a hearing on the request.

5. The NCQAC issues an order granting or denying the request. ACO serves the order.

6. If an evaluation is ordered, and unless the order provides otherwise, OLS provides the following materials to the evaluator(s):

   A. Notice of Intent to Order Mental and/or Physical Examination and supporting documentation provided by the program in support of the request.
   B. Respondent's response (including supporting documentation) to the Notice of Intent to Order Mental and/or Physical Examination, if any;
   C. Order for Investigative Mental and/or Physical Examination.
   D. A detailed cover letter that provides the evaluator with specific direction regarding the scope and purpose of the evaluation.

7. OLS ensures a valid contract is in place with the evaluator before sending supporting materials to the evaluator.

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE

Title:	Licensee HIV/AIDS status	**Number:**	A42.02
Reference:	RCW 70.24.105		
Contact:	Mary Dale, Discipline Manager		
Effective Date:	September 13, 2013		
Supersedes:	HPQA 216, July 14, 2005; August 1, 2012		
Approved:			
	Chair **Washington State Nursing Care Quality Assurance Commission**		

PURPOSE: This procedure establishes a process to assure that HIV/AIDS status is considered appropriately during complaint processing and the identity of HIV/AIDS positive individuals remains confidential.

Conduct potentially endangering the public by an HIV/AIDS positive credential holder may be investigated and action taken if warranted. Positive HIV/AIDS status in the absence of risky conduct is not a violation of law and cases are not investigated.

PROCEDURE:

1. Reports of a licensee with alleged HIV/AIDS are managed by the discipline manager or executive director, assuring the licensee is not identified as HIV/AIDS positive by:
   - Consulting with the investigations and legal managers to determine a course of action
   - Presenting the report at the case management team (CMT) meeting without identifying the individual
   - Focusing investigation and any disciplinary action on the risky conduct
   - Determining information to share with the reviewing commission member
   - Coaching the member on presenting the case without revealing the identity
   - Assuring materials mailed or transmitted to the reviewing member are viewed only by the member through hand delivery or confidential mailing
   - Assuring any file copies are made confidentially

2. HIV/AIDS status is medical information and is not revealed in public disclosure of documents or information.

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE

Title:	Effect of Military Status on Discipline	**Number:**	A43.02
Reference:	RCW 43.70.270; 50 U.S.C. 501-593		
Contact:	Mary Dale, Discipline Manager		
Effective Date:	September 13, 2013		
Supersedes:	HPQA 206, May 02, 2005; August 1, 2012		
Approved:			
	Chair **Washington State Nursing Care Quality Assurance Commission**		

PURPOSE: An applicant or credential holder may be an active member of the military service. This procedure provides consistent treatment of military service members for purposes of credentialing or discipline.

PROCEDURE:

1. Active military service members, while in active duty status, have certain protections from civil action.
   A. The Service Members Civil Relief Act applies to disciplinary actions in administrative law.

      - The Act allows a respondent to obtain a stay of proceedings in the event charges are issued.
      - The health law judge may allow a stay of proceedings upon his or her own motion.

2. Throughout the discipline process, the Integrated Licensing and Regulatory System (ILRS) database is checked for military status ("Military" status).

      - At intake, program staff print the screen and highlight the Credential Status: "Military" and add to the investigative file. At the time case disposition is being decided, program staff recheck for "Military" status.
      - The Office of Legal Services (OLS) checks for "Military" status again before service of either the statement of charges or statement of allegations.

3. In some cases, information regarding active duty military status may be provided by the license holder or other sources, such as the respondent's family, employer, or colleagues.

4. Staff shall notify the Executive Director, normally as part of case management, that a respondent has been identified as being on active duty military status.
   A. The decision regarding whether to place an administrative hold on a case or proceed with legal service will be made on a case-by-case basis in consultation with the Executive Director. The factors include:
      - the nature of the complaint
      - whether the scope of military service includes practice as a health care professional
      - the potential risk of harm if the case is placed on hold pending Respondent's return from active duty
      - respondent's ability and willingness to participate in the process

5. If a complaint contains allegations related to standard of care and a respondent's ability to practice with reasonable skill and safety, and it appears the respondent's military service involves the practice, the Department must notify the appropriate military personnel.

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE

Title:	Withdrawal of Statement of Allegations (SOA)	**Number:**	A44.02
Reference:	RCW 18.130.090		
Contact:	Mary Dale, Discipline Manager		
Effective Date:	September 13, 2013		
Supersedes:	HPQA 243, June 19, 2005; August 1, 2012		
Approved:			
	Chair **Washington State Nursing Care Quality Assurance Commission**		

PURPOSE: There are instances where the Nursing Care Quality Assurance Commission (NCQAC) decides not to pursue the Statement of Allegations (SOA). A SOA is not formally withdrawn since it is not subject to public disclosure until and unless a Stipulation to Informal Disposition (STID) is finalized.

PROCEDURE:

1. The decision to withdraw allegations must be made by the same charging panel that made the initial decision. Staff document the decision using the same process as for case disposition decisions.

2. The withdrawal process is accomplished by a letter when the SOA has been mailed, but the STID has not been signed. The letter to the respondent advises that the allegations are not being pursued any further.

    A. The staff attorney prepares the letter.
    B. If withdrawing the allegations is approved by the NCQAC, the notice is signed by the person who signed the SOA or another person with signature authority delegated by the NCQAC.

    C. The legal unit files the letter with the Adjudicative Clerk Office (ACO). ACO updates the database to reflect the withdrawal.

3. A letter to the complainant notifies them of the case closure.

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE

Title:	Withdrawal of Statement of Charges (SOC)	**Number:**	A45.02
Reference:	RCW 18.130.090		
Contact:	Mary Dale, Discipline Manager		
Effective Date:	September 13, 2013		
Supersedes:	HPQA 242, October 12, 2004; August 1, 2012		
Approved:			
	Chair **Washington State Nursing Care Quality Assurance Commission**		

PURPOSE: The Nursing Care Quality Assurance Commission (NCQAC) may withdraw a statement of charges (SOC) only when new information indicates a SOC is no longer the appropriate disposition.

A stipulation to informal disposition (STID) should not be offered or accepted as settlement to the SOC. A STID should not be used as a tool for "settling" the charges.

PROCEDURE:

1 The decision to withdraw charges must be made by the same charging panel that made the charging decision. Staff document the decision in the same manner as case disposition decisions.

2 The process to withdraw charges depends on whether or not the SOC has been served, and whether the respondent has filed an answer.

A. **SOC not served:** Staff return the case to the charging panel for case disposition decision based on the new information.

- Staff document the new decision and make the appropriate entries in ILRS database.

B. **SOC served, but not answered**: A staff attorney or assistant attorney general prepare a Notice of Withdrawal of Statement of Charges (notice).

1. If NCQAC approves the charges, the notice is signed by the same person who signed the SOC or another person with signature authority delegated by the NCQAC.

2. Office of Legal Services (OLS) files the notice with the Adjudicative Clerk Office (ACO) for service.
for service.

C. **After an answer has been filed:** The SOC is withdrawn through a notice and order.

1. The staff attorney or AAG prepare both the notice for withdrawal and proposed order. That attorney signs the notice and presents the proposed order to the same panel that made the charging decision.

2. ACO presents the notice to the assigned health law judge to issue an order.

3. OLS files the notice and signed order with ACO for service.

D. **STID in lieu of SOC:** If additional information acquired during the adjudicative process suggests the case should be resolved with a STID, the SOC is withdrawn only if the charging panel accepts the STID.

1. The reviewing commission member makes the decision to offer a STID.

2. The staff attorney prepare the SOA and proposed STID. The discipline manager signs the SOA. The package is served on respondent. The SOC is not withdrawn at that time and the case remains in the adjudicative step for tracking purposes.

3. The withdrawal/STID package consists of:
    - STID (signed by the parties)
    - notice and (proposed) order for withdrawal of SOC
    - statement of allegations (SOA) (should be signed prior to presentation)

4. The staff attorney and/or AAG ensure the respondent understands the final decision will be made by the NCQAC. The recommendation of the staff attorney, AAG, or RCM does not bind the NCQAC.
5. The withdrawal and SOA/STID are presented to the NCQAC as a package to

the charging panel.

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE

Title:	Summary Actions	**Number:**	A46.02
Reference:	RCW 34.05.479; RCW 34.05.422; RCW 18.130.370; RCW 18.130.050(7); WAC 246-10-301 THROUGH 306 AND WAC 246-11-300 through 350		
Contact:	Mary Dale, Discipline Manager		
Effective Date:	September 13, 2013		
Supersedes:	HPQA 212,November 01, 2007; HPQA 253; May 02, 2005; & HPQA 256, December 1, 2006; August 1, 2012		
Approved:			
	Chair **Washington State Nursing Care Quality Assurance Commission**		

PURPOSE: This procedure describes the steps required for the Nursing Care Quality Assurance Commission (NCQAC) to take summary action. Summary actions may address issues of imminent danger or when a license holder is prohibited from practicing nursing in another state for conduct that would be unprofessional in Washington. The summary action process involves the rapid restriction or suspension of a nurse's license without prior notice.

PROCEDURE

1. Cases of imminent danger and prohibited practice in another state are identified on complaint intake and assessment.
2. Members of the Expedited Case Management Team (ECMT) recommend the case for possible summary action by the NCQAC.

    A. In the event of out-of-state prohibition, the ECMT will review all cases to determine that:

        1. The other state's prohibition was not based solely upon discipline issued by Washington;

        2. NCQAC has not already considered the out-of-state action. For example, the disciplining authority had information about the conduct resulting in the out-of-state action and either credentialed the applicant or closed the complaint.

        3. The out-of-state prohibition was based on conduct that is substantially equivalent to professional misconduct defined in RCW 18.130.180. Factors include similar statutory/rule language or elements.

B. A mandatory suspension is not required if any of the above factors are not met. If NCQAC already considered the conduct, the case is closed without action. NCQAC may still take action if the other state's action was not a full prohibition or substantially equivalent.

C. This procedure is used for mandatory summary suspensions. The statement of charges alleges violations of RCW 18.130.180(5) unless evidence already exists to support additional charges.

3. A. NCQAC case disposition panel determines whether to recommend summary action.

B. The discipline manager drafts a "hot topic" announcement for all non-mandatory summary actions. The summary coordinator for Office of Legal Services (OLS) reviews the announcement before the Executive Director sends it to the HSQA hot topic distribution list. The discipline manager drafts the proposed news release according to HSQA business practice 1-1-36.

4. A summary action is initiated through a motion process. The staff attorney coordinates with the Attorney General Office (AGO) and prepares the initiating documents. This includes the motion, declaration and exhibits, underlying statement of charges, proposed order, hearing rights notice and answer form.

5. When the initiating documents have been finalized, the legal secretary sets a "face-to-face" scheduling meeting. Participants include staff from Office of Customer Service-Adjudicative Clerk Office (OCS-ACO), OLS and the discipline manager. The group coordinates an anticipated timeline for the summary motion to be heard. The group also tentatively identifies when the order will be served.

6. The initiating documents are submitted to OCS-ACO by the legal secretary on behalf of the NCQAC.
   At the time the documents are filed with OCS-ACO, the Summary Coordinator provides the agreed anticipated timeline to OCS-ACO, DOH Communications Office, and ECMT participants.

7. OCS-ACO schedules the proceeding to consider the motion.

8. OCS-ACO notifies OLS of the outcome.

A. If NCQAC approves the summary action, OLS serves the summary order packet. A copy of the summary order packet may be personally delivered to the respondent at the same time that it is served by mail.

B. If the summary action is not approved, the statement of charges is served and the disciplinary process is completed within normal timelines.

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE

Title:	Surrender of Credentials	**Number:**	A47.02
Reference:	RCW 18.130.160		
Contact:	Mary Dale, Discipline Manager		
Effective Date:	September 13, 2013		
Supersedes:	HPQA 341, July 14, 2005; August 1, 2012		
Approved:			
	Chair **Washington State Nursing Care Quality Assurance Commission**		

PURPOSE: This procedure provides for consistent use of surrender of a credential.

PROCEDURE:

1. Nursing Care Quality Assurance Commission (NCQAC) staff recommend and offer surrender of license to resolve discipline cases in limited circumstances.

    - The nurse must be at the end of his/her effective practice
    - The nurse agrees to retire from practice and not to resume practice
    - Surrender, as the only sanction imposed, is enough to protect the public

2. Surrender agreements must include nurse's agreement:

    - to cease practice and not return to practice
    - to return all credentials reflecting a current expiration date
    - not to practice on an emergency or volunteer basis in the state of Washington

3. Nurses who surrendered a credential will not be allowed to renew, reactivate, or reapply for the credential. Applications for any other profession credentials will be accepted and evaluated as usual.

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE

Title:	Case Status Correspondence	**Number:**	A48.02
Reference:	RCW 18.130.085 and RCW 18.130.095		
Contact:	Mary Dale, Discipline Manager		
Effective Date:	September 13, 2013		
Supersedes:	HPQA 203, July 1, 2005; August 1, 2012		
Approved:			
	Chair **Washington State Nursing Care Quality Assurance Commission**		

PURPOSE STATEMENT:

This Procedure describes the process used for routine disciplinary case status correspondence. There are four major decision points when case correspondence is sent. These include:

- When the case is closed without investigation.
- When the case is closed without legal action after investigation.
- When a statement of charges is issued or when a case is closed after action is taken (stipulation to informal disposition or order issued).
- When a respondent has fully complied with all terms and conditions of a stipulation to informal disposition.

PROCEDURE:

Case Status Correspondence must contain the respondent's name and the case number(s) and the key elements described in this procedure.

In case status correspondence, the respondent's address is never provided to the complainant and the complainant's identity is never provided to the respondent.

1. If the case is closed without investigation, staff send a letter to the respondent and to the complainant.
   The letter to the respondent describes the nature of the report, the reason for closure and states that the respondent may submit a written statement.
   The letter to the complainant describes the reason the case was closed without investigation and states that the law allows the complainant one opportunity to request reconsideration of the disciplinary authority's decision if complainant provides new information about the original complaint within 30 days of receiving the closure letter.

2. If the case is closed without action after an investigation, staff send a letter to the respondent and to the complainant. Each letter describes the reason the case was closed without action.
   The letter to the complainant states that the law allows the complainant one opportunity to request reconsideration of the disciplinary authority's decision if complainant provides new information about the original complaint within 30 days of receiving the closure letter.

3. When a case is closed after action is taken (stipulation to informal disposition or order issued), staff send a letter to the complainant: It describes the action taken and advises that additional information, including copies, can be obtained through Provider Credential Search.

Staff do not send documents with case status correspondence. That process is managed by the Public Disclosure and Records Center. Correspondence describes the process for obtaining public disclosure.

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE

Title:	Substance Abuse Referral Contracts	**Number:**	A49.02
Reference:	RCW 18.130.170; RCW 18.130.180		
Contact:	Mary Dale, Discipline Manager		
Effective Date:	September 13, 2013		
Supersedes:	January 11, 2013		
Approved:			
	Chair **Washington State Nursing Care Quality Assurance Commission**		

PURPOSE STATEMENT: The purpose of this procedure is to set up guidelines for the management of cases in which the respondents admit to a substance abuse issue and agree to enter the Washington Health Professional Services Program (WHPS). After review by the Commission, the case may be closed as a unique closure in compliance with policy A20, Substance Abuse Orders.

PROCEDURE

1. During an investigation, the investigator identifies if unprofessional conduct may be the result of substance abuse. The investigator may send a Substance Abuse Referral Contract (SARC) to the respondent immediately if the case meets all of the following criteria:
   - The respondent admits, in writing, to misuse of controlled substances, alcohol, or other drugs.
   - The unprofessional conduct does not rise to the level of "serious misconduct" as identified in NCQAC policy A20.
   - The respondent has not been previously referred to WHPS in lieu of discipline or ordered into the program.

If the respondent has previously participated in WHPS, the file will be referred to the Substance Use and Abuse Team (SUAT) for an evaluation and a recommendation to the Commission.

2. The investigator sends a SARC to the respondent for signature.
   - If the respondent signs the SARC, the investigator then ensures it is signed by a WHPS case manager.
   - If the respondent refuses to sign the SARC, the investigator completes the investigation as usual.

3. The case file is sent to Case Management after the investigation is completed.

- If the respondent does not have a WHPS contract in place, SUAT administrative personnel checks the WHPS contract status immediately and then every three weeks afterwards.
    - If the respondent does not have a WHPS contract in place after 45 days, in agreement with the SARC, the case is taken back to SUAT for recommendation to the Commission.
- If/when the respondent signs a WHPS contract, the case is presented to the Case Management panel for Unique Closure.
    - If approved for Unique Closure, the original SARC is signed by a CMT panel member or its designee.
- The Commission considers the case for possible discipline:
    - If the respondent refused to sign the SARC, or
    - If the respondent has not signed a WHPS contract within 45 days of signing the SARC.

When a respondent was in WHPS due to their case being closed Unique Closure and the respondent is terminated from WHPS, within five business days of receipt of the WHPS closure letter:

- SUAT administrative personnel opens a new complaint in the database Integrated Licensing & Regulatory System (ILRS).
- SUAT performs an assessment/triage. Items considered during the triage include:
    - WHPS closure letter
    - Prior investigative report(s)
    - SARC (if any)

SUAT administrative personnel writes a recommendation to the Commission based on the triage notes. The new complaint, including the SUAT recommendation, is given to the NCQAC Complaint Intake to continue with the regular complaint process.

Delegation of Decision-Making
(RCW 18.130.050 (10))

The Nursing Care Quality Assurance Commission (NCQAC) delegates final decision-making authority to a Health Law Judge in the Adjudicative Service Unit, Department of Health, for the following activity:

> Expedited hearings involving an alleged violation of RCW 18.130.180 (9) for failure to successfully complete participation in the Washington Health Professional Services (WHPS) program as ordered in a previous order or STID, where the Respondent is not currently eligible to reenter WHPS due to more than one unsuccessful attempt to complete the WHPS program.

This delegation, under RCW 18.130.050 (10), shall remain in effect until revoked, terminated, or modified by the NCQAC.

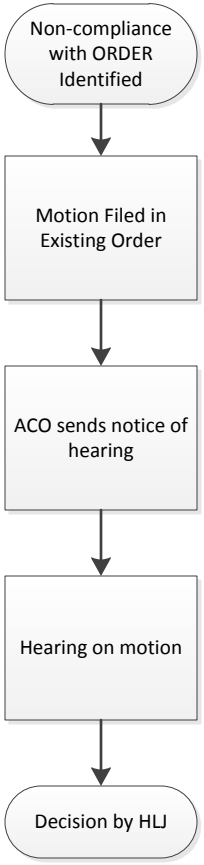
Dated this _____ day of September, 2013.

_____

Suellyn M. Masek, MSN, CNOR
Chairperson
Nursing Care Quality Assurance Commission

Comparison of current "Fast Track" non-compliance vs. proposed Expedited Non-Compliance Hearing

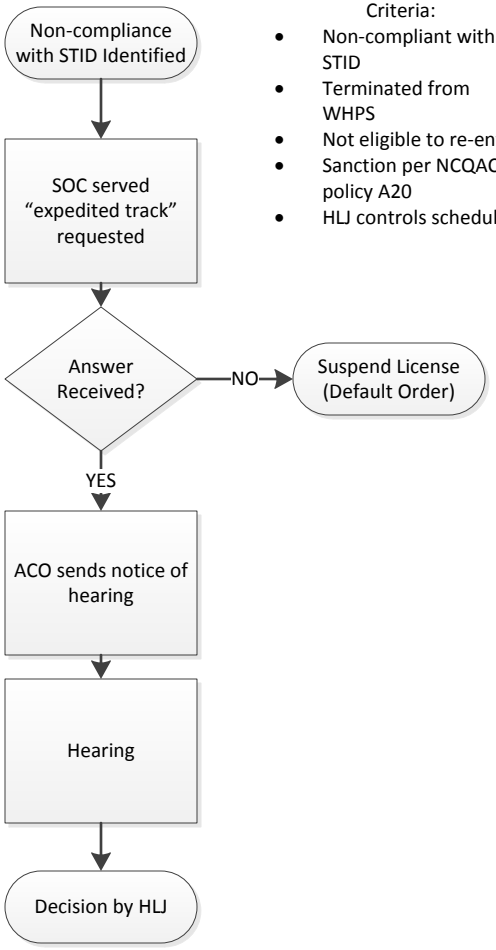
"Fast-Track" Motion



Criteria:

- Non-compliant with **order**
- Indef. Suspension is sanction

Expedited Non-Compliance Hearing



Criteria:

- Non-compliant with STID
- Terminated from WHPS
- Not eligible to re-enter
- Sanction per NCQAC policy A20
- HLJ controls schedule

Sanction Standards for Charging Respondents For
Practice on an Expired License

Description of Violation	Aggravating & Mitigating Factors	Harm (Tier)	Charge	Duration Of Sanction	~~New Fine~~ Penalty	Conditions	Time For Completion
I. Practice on an expired license from 6 to 12 months		N/A	~~SOC~~ Notice of Correction	~~1-3 years~~	~~$1000~~	~~1. Minimum of 3 hours education on the Nursing WAC 246-840 or UDA 18.130~~ None	~~1.60 days~~
II. Practice on an expired license from 1 to 3 years.	Extenuating circumstances	N/A	Notice of Correction			None	
III. Practice on an expired license from 1 to 3 years	No extenuating circumstances involved	N/A	~~SOC~~ SOA	1-3 years	~~$1000 per year~~ Cost recovery	1. Minimum of 3 hours education on the Nursing WAC 246-840 or UDA 18.130 2. Minimum 6 hours education on Time Management 3. Minimum 6 hours education on Ethics	1.60 days 2.60 days 3.60 days
I~~II~~V. Practice on an expired license for over 3 years	~~License application requires refresher course~~	N/A	SOC	1-3 years	$1000 per year	1. Minimum of 3 hours education on the Nursing WAC 246-840 or UDA 18.130 2. Minimum 6 hours education on Time Management 3. Minimum 6 hours education on Ethics 4. May waive the clinical portion of the refresher course (WAC 246-840-130(3)(d) and (h)	1.60 days 2.60 days 3. 60 days

NEW SECTION

WAC 246-840-125 Retired active credential. (1) A registered or licensed practical nurse may place their credential in "retired active" status by meeting the requirements of this section.

(2) A registered or licensed practical nurse who holds a retired active credential may only practice in intermittent or emergent circumstances.

(a) Intermittent means the registered or licensed practical nurse will practice no more than ninety days a year.

(b) Emergent means the registered or licensed practical nurse will practice only in emergency circumstances such as earthquakes, floods, times of declared war, or other states of emergency.

(3) To obtain a retired active credential a registered or a licensed practical nurse must:

(a) Meet the requirements in WAC 246-12-120.

(b) Pay the appropriate fee in WAC 246-840-990.

(4) To renew a retired active credential the registered nurse or licensed practical nurse must:

(a) Meet the requirements in WAC 246-12-130. The retired active credential fee is in WAC 246-840-990.

(b) Have completed forty-five hours of continuing education in compliance with WAC 246-840-203 (1)(a)(iii)(A) through (F). Education may include CPR and first aid.

(c) Demonstrate they have practiced at least ninety-six hours every three years. Practice may be paid or volunteer, but must require nursing knowledge or a nursing license.

(d) Renew their retired active credential every year on their birthday.

(5) To return to active status the registered or licensed practical nurse must:

(a) Meet the requirements in WAC 246-12-140. The active renewal fee is in WAC 246-840-990.

(b) Meet the continuing competency requirements in WAC 246-840-205.

(6) A registered or licensed practical nurse who holds a retired active credential is subject to a continuing competency audit.

(a) All late renewals and a percentage up to five percent of registered and licensed practical nurses renewing their license may be audited by the commission.

(b) A registered or practical nurse being audited will have thirty calendar days to complete and submit to the commission the audit form documenting at least ninety-six hours of active practice, and forty-five hours of continuing nursing education every three years. Active practice hours are not to exceed ninety days each year.

(c) To document practice hours and continuing nursing education a registered or licensed practical nurse shall comply with WAC 246-840-206 (4) and (5).

Department of Health
Nursing Care Quality Assurance Commission

Advisory Opinion

Form Revised – 10/18/11

Title:	Camp Nursing	*Number:* NCIS 3.0
References:	RCW 18.79 Nursing Care: http://apps.leg.wa.gov/RCW/default.aspx?cite=18.79 WAC 246-840 Practical & Registered Nursing: http://apps.leg.wa.gov/WAC/default.aspx?cite=246-840 WAC 246-101 Notifiable Conditions: http://apps.leg.wa.gov/WAC/default.aspx?cite=246-101 RCW 70.02 Medical Records: http://apps.leg.wa.gov/RCW/default.aspx?cite=70.02 RCW 7.70 Informed Consent: http://apps.leg.wa.gov/RCW/default.aspx?cite=7.70.065 RCW 69.41 Legend Drugs-Prescription Drugs: http://www.bing.com/search?q=rcw+69.41&qs=n&form=QBRE&pq=rcw+69.41&sc=8-9&sp=-1&sk= RCW 69.50 Uniform Controlled Substances Act: http://apps.leg.wa.gov/RCW/default.aspx?cite=69.50 WAC 246-376 Camps http://apps.leg.wa.gov/WAC/default.aspx?cite=246-376&full=true WAC 296-126: Standards of Labor: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-126	
Contact:	Deborah Carlson, MSN, RN	
Phone:	360-236-4725	
Email:	Debbie.carlson@doh.wa.gov	
Effective Date:	TBD	
Supersedes:	Medical Personnel at Nurse Camps, February 19, 1999	
Approved By:	TBD	

Conclusion Statement

While there are no State statutes or rules requiring camps to have a camp nurse, the Nursing Commission concludes that registered nurses (RNs) and licensed practical nurses (LPNs) may provide nursing care in camps up to their lawful and individual scope of practice based on their education, skills, knowledge. All statutes and rules apply to nursing care in camp settings as in any other nursing setting whether in a paid or volunteer position. The Nursing Commission recommends nurses use the *Scope of Practice Decision Tree* to determine if an activity is within the nurse's individual scope of practice. This document provides guidance and recommendations for camp nurses.

DOH XXX-XXX September 2013

Background and Analysis

The Nursing Commission received a question in February 1999 requesting an opinion on requirements for medical personnel at camps, and if a nurse is required, how does this affect the nurse's license. State regulations for camps focus on environmental health. Camps are not required to have a camp nurse. The Nursing Commission receives numerous questions about various aspects of nursing practice in camp settings. Nursing care in camps can be challenging. The nurse may be the only health care provider onsite to address health care and safety needs of campers and staff. Camp settings may be in remote areas with limited access to health care services. Camps may have activities that increase risk for injury or illness such as hiking, rock climbing, contact sports and water sports. Environmental factors may also play a role such as exposure to inclement weather, disasters such as forest fires, allergens, rodents, insects, wild animals and dormitory-style living.

Common Roles and Responsibilities of Camp Nurses

RN	**LPN**
• Provide routine and complex nursing care • Carry out medical regimens under the direction of an authorized provider including administration of over-the-counter drugs, herbals, supplements, homeopathic remedies and legend drugs or controlled substances • Monitor campers with chronic conditions, special needs and complex medical treatments • Prevent, monitor and respond to communicable disease outbreaks • Maintain infection control and safety standards • Perform emergency preparedness activities • Observe and report suspected child or vulnerable adult abuse or neglect • Maintain infection control practice standards • Prevent, monitor and respond to communicable disease outbreaks • Store and secure medications, • Perform quality control activities of medical devices such as glucometers • Perform inventory management activities Provide first aid, cardiopulmonary resuscitation (CPR) and emergency care • Develop individualized health plans • Provide routine or complex health promotion and preventive activities for campers and staff • Delegate routine or complex nursing tasks to unlicensed assistive personnel (UAP) • Maintain confidentiality of protected health information (PHI) following Federal HIPAA and State regulations, • Communicate with other health care professionals, parents and other staff as appropriate • Document care using nursing process	• Provide routine nursing care • Carry out medical regimens under the direction and supervision of an authorized provider including administration of over-the-counter drugs, herbals, supplements, homeopathic remedies and legend drugs or controlled substances • Monitor campers with chronic conditions, special needs and routine medical treatments • Prevent, monitor and respond to communicable disease outbreaks • Maintain infection control practice and safety standards, • Perform emergency preparedness activities • Observe and report suspected child or vulnerable adult abuse or neglect • Maintain infection control practice standards • Prevent, monitor and respond to communicable disease outbreaks • Store and secure medications • Perform quality control activities of medical devices such as glucometers • Perform inventory management activities • Provide first aid, cardiopulmonary resuscitation (CPR) and emergency care • Assist the RN to develop individualized health plans, • Provide routine health information and promotion activities for campers and staff • Delegate routine nursing tasks to unlicensed assistive personnel (UAP) • Maintain confidentiality of protected health information (PHI) following Federal HIPAA and State regulations, • Communicate with other health care professionals, parents and other staff as appropriate, and • Document care using nursing process

Nurse Competency

Basic competencies for camp nurses include the knowledge, skill and ability to perform the following within their individual scope of practice:

- Adapt nursing care to the camp setting,
- Develop or assist in developing individualized health plans using the nursing process based on the general and specialized health care needs of the campers,
- Coordinate health activities with routine camp activities,
- Provide nursing care for common health problems found in camp settings for healthy individuals and those with common chronic health conditions such as diabetes, asthma, allergies, seizures, behavioral or emotional disorders,
- Provide first aid and emergency care for individuals or in a natural or manmade disaster
- Plan and provide health promotion and illness prevention activities in the camp setting,
- Follow infection control practices, communicable disease control practices, mandatory reporting practices and safety practices in the camp setting,
- Recognize and provide nursing care specific to age, growth and development, socioeconomic background, health status, geographical location, physical location, daily schedule, risk profile and other factors to determine health risks to campers and staff,
- Communicate with health care providers, parents, campers and staff,
- Maintain confidentiality of PHI in a camp setting.

Recommendations

Health and Wellness

A health history and nursing assessment is fundamental to determining the health care needs of campers or staff. Written consent is required for treatment from parent or legal guardian for children under 18 years of age and applies to campers and staff. Consent for treatment is recommended for staff 18 years and older. Authorization for medical treatment should be in writing from the camper's health care provider. A nurse can give medical care in an emergency without written consent. The nurse should be actively involved safety, emergency preparedness and infection control and illness prevention strategies. Activities should include immunization and health history review of campers and staff identifying those who may be more at risk, Staff orientation should include injury and illness prevention, infection control and blood-borne pathogen prevention and exposure training including use of helmets or other protective equipment relevant to the camp setting. The nurse should perform monitoring and surveillance activities.

Nursing Process, Care Planning and Care Coordination

The RN, when developing the individualized health care plan, should consider the medical history, restrictions, increased risk for communicable diseases, limitations and special needs, medications, emergency care plan, chronic illness care, level of self-management and advance directives.

Medical Standing Orders

Medical standing orders provide care directives from an authorized provider that describes the parameters of specific situations, under which the nurse may act to carry out specific medical orders for an individual who presents with symptoms or needs addressed in the standing orders. Standing orders, signed and dated by the authorized provider, outline the assessment and interventions that a RN or LPN may perform. There should be policies in place that allow use of standing orders at the camp and a description of the process for developing, approval, review and revision. Examples in camp settings may include treatment of common health problems, first aid and emergency care, screening activities and occupational health services. Nurses may provide nursing assistance in cases of emergency. RCW 18.79.240. The camp nurse must only carry out medical standing orders that are with the nurse's individual scope of practice.

Medication Management

Camp RNs and LPNs may not prescribe or dispense (interpret a prescription for a legend drug or select, measure, compound, label or package) a legend drug. RCW 69.41.010. Camp nurses may administer medications from an appropriately labeled, pre-packaged container with a valid order and prepare medication organizers using medications from pharmacy prepared containers. RCW 18.79.040, RCW 18.79.060, RCW 69.41.050. Pharmacy prepared bubble packing is recommended for routine medications. Nurses must have written consent from an authorized person to give legend and non-legend drugs to children under 18 years old or for someone who is not competent, except in an emergency. RCW 7.70.065. Authorization to give legend drugs and over-the-counter drugs, herbals, supplements or other homeopathic remedies should be in writing from the camper's health care provider and the camper's parent or legal guardian. Medications should be stored and secured appropriately. Medications should not be stored with food. Medications should be maintained at proper temperature and internal medications (oral, injectable) and external medications (topical, eye, ear and rectal) distinctly separated. Controlled substances should be under lock except during administration and accountability processes in place. WAC 246-887-260, WAC 246-887-270. The nurse should consider privacy issues when giving medications. In the camp setting, unless the camp is an extension of a state-approved school, a nurse may not delegate administration of medications to unlicensed assistive personnel (UAP) except in a life-threatening situation. RCW 18.79.240.

Delegation

Many camps employ unlicensed assistive personnel (UAP) staff to help deliver health care. The nurse is legally responsible for directing and supervising delegated nursing actions. RNs may delegate to UAP in carrying out duties to support nursing services. RCW 18.79.240, WAC 246.840-700. LPNs may delegate routine, non-complex nursing care. 246.840-700. UAP must be at least 18 years old to perform delegated nursing tasks. 296.125.030. Nurses may not delegate medication administration, medication assistance, catheter care, blood glucose monitoring, ventilator or tracheostomy care, tube feedings or other tasks that require substantial skill or nursing judgment except in life-threatening situations.18.79.240. The school nurse may delegate activities as allowed by State statutes and rules in a camp under the jurisdiction of an approved public or private school. RCW 28A.210. The delegating nurse must determine the competency of the individual before delegation, evaluate the appropriateness of the delegation, and supervise the actions of the person performing the task, RCW18.79.260, determining what level of supervision is necessary.

Communication and Documentation

Documentation in a health care record is a common way of communicating information to staff, parents and other health care providers. The nurse must document care provided including assessments, plans, interventions, outcomes, medication records, release of personal health information (PHI) and other health care activities. Camp nurses are responsible for communicating and documenting significant changes in status to the appropriate health care provider within an appropriate timeframe and method depending on the situation. WAC 246-840-700. Documentation of nursing care must reflect the nursing process. The health record should contain current medical history and physical, immunization records, confidentiality agreements, consent forms, authorization to release health records, emergency contact information, advanced directives and insurance information. The nurse is responsible for documenting medication and treatments given and should clearly reflect when following medical standing orders. The nurse should follow the Washington State Labor and Industry procedures to document and report work-related injuries. Other commonly used documentation methods such as medication and supply inventory tracking systems, surveillance tools, injury and illness reporting systems. Based on national standards and Washington State hospital medical record retention requirements, RCW 70.02.160, the Nursing Commission recommends camp nurses:

- Retain and preserve health care records for campers and staff 18 years and older for at least ten years following the most recent care episode,
- Retain and preserve health care records for campers and staff under 18 years old for at least three years after turning 19 years old or ten years after the most recent care episode,

Retention and preservation for at least one year is required for at least one year after receiving or processing an authorization to release information. RCW 70.41.190.

Privacy and Confidentiality of Protected Health Information (PHI)

Camp nurses must maintain and secure medical records in compliance with State statutes, RCW 70.02, and the Health Care Affordability and Accountability Act (HIPAA) and typically cannot release any protected health information without written authorization of from the patient, parent or legal guardian except on a need-to-know basis with another health care provider. Other exceptions include mandatory reporting of notifiable conditions, WAC 246-101 and suspected abuse or neglect of children or vulnerable adults. RCW 26.55.030.

Licensure and Certification

Nurses must have an active Washington State nursing license. RCW 18.79.030. Nurses accompanying campers to another state need to check with that state to determine if they need a nursing license from that state. Nurses licensed in another state may provide care for a patient temporarily in Washington for up to six months without an in-state license. While there is no requirement for a certification as a camp nurse, the camp may require a specific training course or professional certification in camp nursing or other specialty areas. RCW 18.79.240.

The Nursing Commission does not have authority to require professional liability insurance establish working hours, on-call status, compensation, assignment, camper-nurse ratios or other employer-employee issues. Camps, as employers, can define the employees' jobs more narrowly than the full scope of practice allowed by law.

Conclusion

Camp nurses are responsible and accountable for giving safe, effective and ethical care that follows Washington State and Federal regulations. The care they provide must be consistent with their knowledge, skills, critical thinking and judgment in order to address campers' health care needs and to manage routine, complex and emergency situations. The nurse is responsible for understanding regulations and functioning within the legal scope of practice.

References

Association of Camp Nurses (2007*). Best practice statement: Medication management for day and resident camps.* CompassPoint, 17(4), 4.

Association of Camp Nurses (2005). *The Scope & Standards of Camp Nursing Practice*.

Bruckner, E. , Erceg, L.E., Gordon, A., Knippel, M, 2007. The World of Camp Nursing: Volume 2 Safety Guide: http://www.campinsurance.com/Site%20Collection%20Documents/PDFs/Nursing%20tip%202.pdf

Baird, S.B. & Montejano, L.B. (2006). Association of Camp Nurses. Roles & Responsibilities of Seasonal and Year-Round Camp Nurses: Survey Results Part I: http://www.acn.org/edcenter/selected_articles/baird1.pdf

Baird, S.B. & Montejano, L.B. (2007). Association of Camp Nurses. *Roles and Responsibilities of Seasonal and Year Round Camp Nurses:* http://www.acn.org/edcenter/selected_articles/baird2.pdf

College and Association of Registered Nurses of Alberta (2008). Camp Nursing: Guidelines for Registered Nurses,

Erceg, L.E. (2011). Association of Camp Nurses. *Communicable Disease Management in Camp Setting:* http://www.acn.org/edcenter/selected_articles/communicable_disease_management_strategies_for_the_camp_setting.pdf

Erceg, L.E. (2004). Association of Camp Nurses. Health Histories: What Are Camps (Not) Asking?: http://www.acn.org/edcenter/selected_articles/healthhistories.pdf

Erceg, L.E., & Pravda, M. (2009). *The Basics of Camp Nursing*.

Gaslin, T.C. & Weinberg, S.T. American Camp Association. Electronic Medical Records in the Camp Setting: HIPAA Considerations: http://www.acacamps.org/campline/winter-2012/electronic-medical-records-camp-hipaa-considerations

State of Washington, Office of Superintendent of Public Instruction and the Department of Health (2004). *Infectious Disease Control Guide for School Staff:* http://www.k12.wa.us

State of Washington, Office of Superintendent of Public Instruction (2001). *Administration of Medication in Schools:* http://www.k12.wa.us

Washington State Department of Labor & Industries (2013). *Guide to Workplace Safety & Health in Washington State: What Every Employer & Worker Needs to Know: http://lni.wa.gov/IPUB/416-132-000.pdf*

Department of Health
Nursing Care Quality Assurance Commission

Advisory Opinion

The Nursing Care Quality Assurance Commission (NCQAC) issues this advisory opinion in accordance with WAC 246-840-800. An advisory opinion adopted by the Nursing Commission is an official opinion about safe nursing practice. The opinion is not legally binding and does not have the force and effect of a duly promulgated regulation or a declaratory ruling by the Nursing Commission. Institutional policies may restrict practice further in their setting and/or require additional expectations to assure the safety of their patient and/or decrease risk.

Title:	Registered Nurse First Assistant (RNFA)	*Number:* NCAO X.XX
References:	RCW 18.79: http://apps.leg.wa.gov/RCW/default.aspx?cite=18.79&full=true WAC 246-840: http://apps.leg.wa.gov/WAC/default.aspx?cite=246-840	
Contact:	Deborah Carlson, MSN, RN	
Phone:	360-236-4725	
Email:	Debbie.carlson@doh.wa.gov	
Effective Date:	TBD	
Supersedes:	RFNA: Registered Nurse First Assistant at Surgery, March 9, 2001	
Approved By:	TBD	

Conclusion Statement

It is within the scope of practice of a Registered Nurse (RN) who can demonstrate the necessary competency to practice as a registered nurse first assistant (RNFA). While not required by statute, the Nursing Commission recommends certification in perioperative nursing (CNOR) and successful completion of an RNFA program that meets the Association of periOperative Registered Nurses AORN standards for RNFAs. ARNPs may function in the role of an RNFA up to their full scope of practice within their certification. The Nursing Commission recommends following the current *AORN Standards and Recommended Practices for Perioperative Nursing*, *AORN Competency Statements for RNFAs*. The Nursing Commission also recommends the facility in which the RNFA practices establish a process to grant clinical privileges to the RNFA. Practice standards prohibit the RNFA from concurrently functioning as scrub nurse. Because of the complex role of an RNFA, the Nursing Commission determines that it is not within the scope of practice for a licensed practical nurse (LPN) to be in the role of a first assistant.

Background and Analysis

The RNFA practices an expanded and complex role in perioperative nursing to provide direct assistance to the surgeon in all phases of surgery. The increasing complexity of surgery provides the perioperative nurse who has expanded perioperative nursing education with the opportunity to practice in collaboration with and at the direction of the surgeon. The complexity of the surgery determines when a first assistant is medically necessary. The RNFA functions include preoperative patient management in collaboration with other health care providers, intraoperative performance of surgical first assistant techniques, and postoperative patient management in collaboration with other health care providers.

Technical skills may include handling tissue, providing exposure, using instruments, applying clamps, harvesting veins, dissecting, providing hemostasis, securing drains, tying knots, suturing skin and tissue associated with the surgical procedures being performed. The RNFA may need to perform cardiopulmonary resuscitation and advanced cardiac life support (adult, pediatric, neonatal depending on patient population) to stabilize the patient if the primary surgeon becomes incapacitated.

Employers may define employees' job description as more restrictive than lawful full scope of practice. An employer or facility may require a specific certification or training and be more restrictive in the scope of practice allowed considering many factors such as liability, accreditation standards and reimbursement. Employers or health care organizations may require credentialing and privileging of RNFAs. The Nursing Commission does not have authority regarding these issues.

Conclusion

RNs may function as an RNFA in the perioperative setting up to the fullest extent within their individual scope of practice. ARNPs can function up to their full scope of practice in an RNFA role within their certification.

References

Association of periOperative Registered Nurses (AORN) Position Statement on RN First Assistants (2012): http://staging.aorn.org/Clinical_Practice/Position_Statements/Position_Statements.aspx

Association of periOperative Registered Nurses (AORN) Position Statement on RN First Assistants (2012): http://www.aorn.org/Clinical_Practice/RNFA_Resources/RNFA_Competency.aspx

Department of Health
Nursing Care Quality Assurance Commission

Interpretive Statement

Revised – 10/18/11

Title:	Delegation for Administration of Rectal Diazepam (Diastat®) to Unlicensed Assistive Personnel (UAP) for Status Epilepticus	*Number:* NCIS 2.0
References:	Registered Nursing Practice, RCW 18.79 http://apps.leg.wa.gov/RCW/default.aspx?cite=18.79 Practical and Registered Nursing, WAC 246-840 http://apps.leg.wa.gov/WAC/default.aspx?cite=246-840 Health – Screening Requirements http://apps.leg.wa.gov/RCW/default.aspx?cite=28A.210	
Contact:	Deborah Carlson, MSN, RN – Nurse Practice Advisor	
Phone:	360 236-4725	
Email:	Debbie.carlson@doh.wa.gov	
Effective Date:	TBD	
Supersedes:	RN Coordinating Seizure Management Statement (Date Unknown)	
Approved By:	Nursing Care Quality Assurance Commission	

Statement

The Nursing Commission concludes that Registered Nurses (RNs) may delegate administration of rectal Diazepam (Diastat®), commonly known as Rescue Seizure Medication (RSM), in the school setting to unlicensed assistive personnel (UAP) for life-threatening seizures. The Commission defines a life-threatening condition as a severe injury or medical condition that, if not immediately treated, puts the person in danger of serious complications or cause permanent damage or death. The Commission defines life-threatening seizures (status epilepticus) as those lasting over five minutes. The RN is responsible and accountable for evaluating the appropriateness of the delegation of a RSM, determining the competency, supervising the actions of UAP performing the delegated task and acting as a patient advocate for the student.

Background

This interpretive statement responds to a request from the Office of the Superintendent of Public Instruction (OSPI) and the School Nurse Organization of Washington (SNOW) for an interpretive statement to address care of students with status epilepticus considering the risks and benefits. RCW, 28A.210.260, permit RNs to delegate administration of oral, ear, eye, topical and intranasal medications to UAP in school settings. RNs may delegate administration of injectable epinephrine for anaphylaxis to UAP because of the need to provide timely treatment to prevent serious consequences or death. RCW 18.79.240. The decision to delegate needs to include whether the nursing process is required to provide the care safely. WAC 246-840-700. The nursing statute, RCW 18.79.240,

prohibits an RN from delegating nursing practice to UAP except when furnishing nursing assistance in a case of emergency. 18.79.240. School statutes define a life-threatening condition as a health condition that puts the student in danger of death during the school day if a medication or treatment order and a nursing plan are not in place. RCW 28A.210.320. RNs may delegate to others when the nurse determines it is in the best interest of the patient. RCW 18.79.260. Before a RN may delegate this activity to UAP, the nurse must:

- Determine if the activity is within the nurse's individual scope of practice. RCW 18.79.040, WAC 246-840-700.
- Decide whether it is appropriate to delegate this activity. WAC 246-840-930, WAC 246-840-706.
- Consider if a reasonable and prudent nurse would delegate this activity. WAC 246-840-010.
- Develop a student-specific care plan, using the nursing process, appropriate and safe for the student. RCW 18.79.230, WAC 246-840-010.
- Provide UAP appropriate training and competency to carry out the task. RCW 18.79.
- Provide adequate supervision of UAP to prevent unreasonable risk of harm to the student. WAC 246-840-710. Supervision means the provision of guidance and evaluation for the accomplishment of a nursing task or activity with the initial direction of the task or activity; periodic inspection of the actual act of accomplishing the task or activity and the authority to require corrective action. WAC 246-840.010.
- Rescind delegation if, at any time, the RN determines student safety may be compromised and develop an alternative plan. RCW 246-840-960.
- Recognize that the decision to delegate to UAP remains only with the RN. RCW 18.79.040, WAC 246-840-700.
- Determine if, within their clinical judgment, the care is safe or unsafe to delegate (RCW18.79.260).
- Recognize that delegating nursing care to a person without the ability or knowledge to perform the task safely is subject to disciplinary action. RCW 18.130, WAC 246-840-700, 246-840-701.
- Recognize that regulations protect nurses from coercion, employer reprisal and disciplinary action by the Nursing Commission for refusing to delegate or refusing to provide required training for delegation if the nurse determines delegation may compromise patient safety. RCW 18.79.260.
- Communicate appropriately with the health care provider, school staff, parents and other individuals involved in the care of the student in developing the care plan or if there are significant changes in the student's status. WAC 246-840-010.
- Act as a patient advocate for the student in health maintenance and clinical care. WAC 246-840-700.

Conclusion

The Nursing Commission determines that RNs may delegate administration of rectal Diazepam (Diastat®) to UAP for life-threatening seizures. Delegation can only take place if the RN determines that it is safe for the student. The RN plays an important role as a patient advocate for the student - actively supporting the patient rights and choices, including the right to receive safe, high quality care. WAC 246-840-010.

Department of Health
Nursing Care Quality Assurance Commission

Advisory Opinion

The Nursing Care Quality Assurance Commission (NCQAC) issues this advisory opinion in accordance with WAC 246-840-800. An advisory opinion adopted by the Nursing Commission is an official opinion about safe nursing practice. The opinion is not legally binding and does not have the force and effect of a duly promulgated regulation or a declaratory ruling by the Nursing Commission. Institutional policies may restrict practice further in their setting and/or require additional expectations to assure the safety of their patient and/or decrease risk.

Title:	Delegation for Administration of Rectal Diazepam (Diastat®) to Unlicensed Assistive Personnel (UAP) for Status Epilepticus *Number:* NCAO X.XX
References:	RCW 18.79: http://apps.leg.wa.gov/RCW/default.aspx?cite=18.79&full=true WAC 246-840: http://apps.leg.wa.gov/WAC/default.aspx?cite=246-840
Contact:	Deborah Carlson, MSN, RN
Phone:	360-236-4725
Email:	Debbie.carlson@doh.wa.gov
Effective Date:	TBD
Supersedes:	Registered Nurses Coordinating Seizure Management (Undated)
Approved By:	TBD

Statement

This advisory opinion responds to a request from the Office of the Superintendent of Public Instruction (OSPI) and the School Nurse Organization of Washington (SNOW) for an interpretive statement to address care of students with status epilepticus. While Registered Nurses (RNs) may legally delegate the rectal administration of Diazepam (Diastat®) in a school setting to unlicensed assistive personnel (UAP) in the event of a student having a life-threatening seizure, the Nursing Care Quality Assurance Commission (NCQAC) evaluated the risks and benefits of this delegation. After a comprehensive review of evidence-based research, stakeholder input, and State nursing statutes and rules, the NCQAC concludes that delegation of the administration of rectal Diazepam (Diastat®) to UAP, also known as rescue seizure medication (RSM), may be an option for emergency treatment of life-threatening seizures. Existing law, RCW 18.79.240, allows RNs to delegate nursing care in the event of an emergency. The NCQAC considers a life-threatening seizure to be a seizure lasting five minutes or more (status epilepticus) that puts a student at risk for hypoxia. The NCQAC weighed risk factors and considered the benefits of stopping life threatening seizures with the potential serious consequences of administration of RSM. This advisory opinion does not apply to non-life threatening (benign) seizures.

Background

A comprehensive literature review, school nurse survey and stakeholder input demonstrate that delegation of RSM to UAP is controversial. While some studies show that giving rectal Diazepam (Diastat®) by caretakers in home settings, is safe and effective, there are few studies supporting the safety and efficacy of rectal Diazepam (Diastat®) administered by unlicensed staff in the school setting. Many schools do not have full time nurses on site or readily available to provide emergency care for students. Public attitudes affect perceptions of whether it is safe to delegate administration of RSM to UAP. Common issues raised include inability to recognize seizure emergencies, monitoring, potential need for cardiopulmonary resuscitation (CPR), privacy, staff anxiety, fear, embarrassment, potential allegations of sexual abuse complaints, unwilling staff and lack of access or availability of an on-site nurse.

The NCQAC believes best practices dictate that students, who experience status epilepticus, have access and availability to an RN who is fully competent in providing care that includes:

- Emergency care plan describing treatment at all times for the student
- A comprehensive nursing assessment including respiratory and neurologic function,
- Competence in administering rectal Diazepam (Diastat®),
- Access to Emergency Medical Services (EMS) contact and transfer, and
- Immediate contact with the student's parent(s) or legal guardian.

Student advocacy is a responsibility of the RN to make sure the student is receiving high quality, safe care. WAC 246-840-700. RNs must have the training, knowledge, skills and ability to provide care competently prior to delegating any activity (RCW 18.79.260). While statutes and rules do not prohibit delegation of RSM, the safety and welfare of the student is the primary consideration. It is not safe to delegate unless the UAP is willing, able and available to perform the task competently. Delegation is the responsibility of the RN. The decision to delegate is limited only to the RN who has the accountability and responsibility for delegation (RCW 18.79.040). A parent or guardian, school administrator, or student's medical provider do not have the authority to delegate this activity to UAP. Regulations protect the RN from coercion to delegate if the nurse does not feel it is safe to do so, RCW 18.79.040, and protection from employer reprisal or disciplinary action by the Nursing Commission for refusing to delegate tasks or refusing to provide required training for delegation if the RN determines delegation may compromise patient safety. Delegation is an ongoing process and may be rescinded at any time the nurse determines it is no longer safe (RCW 18.79.260). RNs should limit delegation only for situations when all other options are exhausted, including:

- Placing the student in a school with a full-time RN or LPN,
- Restriction of administration of RSM to an RN or LPN if on site, or
- One-to-one RN or LPN student assignment.

Recommendations for Safe Practice:

- Develop policies, procedures and protocols addressing:
    - Delegation authority, responsibility and accountability of the RN,
    - Individual emergency seizure care plan process and assignments,

  - Training and competency assessment plan,
  - Employee protection from coercion or pressure to accept delegation assignment,
  - Process for approving, monitoring, and rescinding delegation,
  - Documentation requirements,
  - Medication storage and security,
  - Staff and student safety,
  - Management of special circumstances such as field trips, bus rides, swimming pools, hallways, or wheelchair bound students,
  - Communication process with parent or guardian, administration, EMS, and other health care providers, and
  - Protecting student privacy.
- Obtain written consent from the parent or legal guardian,
- Obtain prescription and instructions from the student's health care provider,
- Develop a seizure action plan, using nursing process, in collaboration with the parent or legal guardian, student, appropriate school staff and other health care providers,
- Provide training (annually or more often as needed) and competency assessment for UAP and other school staff as appropriate that includes:
  - First aid and CPR certification and immediate first aid techniques and CPR for the management of seizures,
  - Education about seizures and epilepsy including prevention, recognition and treatment of different types of seizures, protection from injury and post-seizure aftercare,
  - Drug information including side effects, adverse reactions and administration techniques,
  - Blood-borne pathogen and employee safety training,
  - Techniques and procedures to ensure privacy and emergency follow-up,
  - Medication access, storage and security, and
  - Individualized student-specific training and competency assessment.
- Establish communication, evaluation, follow-up, documentation and monitoring of uncontrolled seizure incidents requiring the use of rectal Diazepam (Diastat®).

Conclusion

The Nursing Commission determines that RNs may delegate administration of rectal Diazepam to UAP for life-threatening seizures. Delegation can only take place if the RN determines that it is safe for the student. The RN plays an important role as a patient advocate for the student - actively supporting the patient rights and choices, including the right to receive safe, high quality care. WAC 246-840-010.

References:

American Academy of Pediatrics, Committee on School Health Policy Statement (2004). Guidelines for the Administration of Medication in School. *Journal of School Nursing*, 20 (2), 65-68. http://pediatrics.aappublications.org/content/112/3/697.full

American Nurses Association (2006). Delegation – Joint ANA and National Council of State Boards of Nursing Position Statement. https://www.ncsbn.org/Delegation_joint_statement_NCSBN-ANA.pdf

deHaan, G.J., van der Gest, P., Doelman, G., Bertram, E., & Edelbroek, R. (2010). A Comparison of Midazolam Nasal Spray & Diazepam Rectal Solution for the Residential Treatment of Seizure Exacerbations. *Epilepsia*, 51 (3), 478-482. http://www.ncbi.nlm.nih.gov/pubmed/19817813

Doyle, J. (2012). SNOW School Nurse Survey on Delegation of RSM.

Epilepsy Foundation (2004). Administration of Medication in Schools, Daycare & Camps Position Paper.

Farris, K.B., McCarthy, A.M., Kelly, M.W., Clay, D., & Gross, J.N. (2003). Issues of Medication Administration & Control in Iowa Schools. *Journal of School Health*, 73(9), 331-337. http://www.ncbi.nlm.nih.gov/pubmed/14689769

Ficca, M., & Welk, D. (2006). Medication Administration Practices in Pennsylvania Schools. *The Journal of School Nursing*, 22(3), 148-155.

Figsin, T., Gurer, Y., Tezic, T., Senbil, N., Zorlu, P., Okuyaz, C., & Akgun, D. (2002). Effects of Intranasal Midazolam & Rectal Diazepam on Acute Convulsions in Children. *Journal of Child Neurology*, 17(2), 123-126. http://www.bmj.com/content/321/7253/83

Washington State Nurses Association. Administration of Medications Position Paper (2012). http://www.wsna.org/practice/publications/documents/pp.medications.pdf

Holsti, M., Sill, B.L., Firth, S.D., Filloux, F.M., Joyce, S.M., & Furnival, R.A. (2007). Prehospital Intranasal Midazolam for the Treatment of Pediatric Seizures. *Pediatric Emergency Care*, 23(3), 148-153. http://sitemaker.umich.edu/emjournalclub/article_database/da.data/1619754/PDF/nasal_midazolam_se_pec.pdf

Holsti, M., Dudley, N., Schunk, J., Adelgais, K., Greenberg, R., Olsen, C., Healy, A., Firth, S., & Filloux, F. (2010). Intranasal Midazolam vs. Rectal Diazepam for the Home Treatment of Acute Seizures in Pediatric Patients with Epilepsy. *Archives of Pediatric Adolescent Medicine*, 164(8), 747-753). http://archpedi.jamanetwork.com/article.aspx?articleid=383593

Kyrkou, M., Harbord, M., Kyrkou, N., Kay, D., Coulthard, K. & Bailey, K. (2006). Impact of a Protocol Using Intranasal Midazolam for Managing Seizures. *The Epilepsy Report*. 19-22. http://www.epilepsyaustralia.net/Publications/Archives/kyrkou_midazolam.pdf

Martin, J. (2005). Acute Repetitive Seizures & Seizure Emergencies: Weighing your Treatment Options. *Epilepsy Therapy Project.*
McMullan, J., Sasson, C., Pancioli, A., & Silbergleit, R. (2010). Midazolam vs. Diazepam for the Treatment of Status Epilepticus in Children and Young Adults: A Meta-Analysis. *Academic Emergency Medicine* 17, 575-582. http://deepblue.lib.umich.edu/bitstream/handle/2027.42/79121/j.1553-2712.2010.00751.x.pdf?sequence=1

National Association of School Nurses (2012). Medication Administration in the School Setting Position Paper. http://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tabid/462/ArticleId/86/Medication-Administration-in-the-School-Setting-Revised-2011

O'Dell, C., & O'Hara, K. (2007). School Nurses' Experience with Administration of Rectal Diazepam Gel for Seizures. *The Journal of School Nursing*, 23(3), 166-169. http://www.ncbi.nlm.nih.gov/pubmed/17536921

O'Dell, C., & O'Hara, K., Kiel, S., & McCullough, K. (2007). Emergency Management of Seizures in the School Setting. *The Journal of School Nursing*, 23(3), 158-165. http://www.ncbi.nlm.nih.gov/pubmed/17536920

Johnson, K. (2012). OSPI Response to NCQAC Draft Interpretive Statement on the Administration of RSM for Students with Seizures.

Resha, C., (2010). Delegation in the School Setting: Is it a Safe Practice? *Online Journal of Issues in Nursing*, 15(2).

State of California Department of Education, Administration of Emergency Anti-Seizure Medication by Trained Volunteer Non-medical School Personnel Code of Regulations (2012), Title 5. http://www.oal.ca.gov/res/docs/recent_actions_emergencies/2012-0316-03E.pdf

Nelson, L. (2012). SNOW Response to Draft Interpretive Statement on the Administration of RMS for Students with Seizures.

Tennessee Department of Health & Tennessee Department of Education (2009). Guidelines for the Emergency use of Anti-Seizure Medication in Tennessee Schools. http://tennessee.gov/education/schoolhealth/healthservices/doc/DiastatGuidelinesFinal3-20102.pdf

Whitesell, M. (2009). Intranasal Midazolam vs. Rectal Diazepam for Acute Management of Prolonged Seizures without Intravenous Access: A Synthesis of the Evidence-Based Research. *Journal of Pediatric Health Care*, e29. http://www.acestar.uthscsa.edu/institute/su08/documents/85Whitesellckd.pdf

Wilson, M.T., Macleod, S., O'Regan, M.E. (2004). Nasal/Buccal Midazolam Use in the Community. *Archives of Disease in Childhood*, 89, 50-52. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1755919/pdf/v089p00050.pdf

CBC CRIMINAL BACKGROUND CHECK

CALL TO ACTION

Criminal Background Checks (CBCs) for Nurse Licensure: Frequently Asked Questions (FAQs)

Criminal background checks (CBCs) are a priority for all boards of nursing. All boards of nursing ask applicants to provide specific information about any past criminal history and this is evaluated prior to licensure. Many of the states without fingerprint-based CBCs have made numerous attempts at passing legislation. However, the bills to date have not successfully passed for a variety of reasons. States will continue efforts to obtain this authority.

Why do boards of nursing (BONs) conduct CBCs?

The profession of nursing requires a high degree of skill and responsibility. Often, nursing involves working with vulnerable individuals who rely on BONs to assure that health care providers are safe and competent. The level of trust that comes with the practice of nursing coupled with the ease of mobility between jurisdictions requires BONs to be vigilant in properly assessing the qualifications of nurses. One step in this process is the utilization of fingerprint-based state and federal CBCs for nurses upon application for initial, endorsement; reinstatement and renewal of licensure to assure individuals with criminal histories are screened for their ability to safely practice nursing.

What methods are used to obtain fingerprints?

Two methods of conducting fingerprints are available: ink and paper, and electronic scanning.

- The ink and paper method requires rolling the individual's fingers in ink and carefully printing them on fingerprint cards. Using ink and paper can be time consuming and labor intensive. Fingerprints are more often rejected when conducted using this method due to the increased potential for error.

- Electronic methods of fingerprinting include Livescan and Cardscan. Livescan devices capture fingerprint images directly from subjects' fingers, which are rolled onto glass scanning plates. Cardscan devices scan and digitize standard inked fingerprint cards and can transmit electronic images with related textual data to remote sites for printout or direct use. Electronic scanning, or Automated Fingerprint Identification Systems (AFIS), as referenced by the FBI, allows for fingerprint images to be scanned and transmitted directly to local law enforcement offices. The ability to send the image electronically allows for a faster and more accurate process.

What is the cost of a CBC?

Service costs range from $30–$75.

Who pays the cost of a CBC?

Jurisdictions can choose to place the cost of the service on the applicant/licensee as a separate fee or add the cost to the licensing fee (if allowed).

Who collects the information for a CBC?

Currently, there are three ways that BONs handle information collecting for CBCs: in-house, through local law enforcement agencies or by utilizing approved private sector corporations.

- Jurisdictions that conduct fingerprinting at their BON have the proper equipment needed, trained staff and safe repository for all information pertaining to the CBC. BONs that conduct CBCs in-house have received positive feedback from their nursing constituents as it allows nurses to meet with BON staff and ensure that they are correctly following protocol.

- Some jurisdictions prefer to stay separate from the fingerprinting process to avoid the time and resources it could involve. In this case BONs refer nursing licensure applicants to a local law enforcement agency where information is collected and reported results are transmitted to the BON.

- Other jurisdictions contract with or accept CBCs from approved corporations dedicated to providing fingerprinting and identity services to public and private sector agencies and organizations. All equipment used by the corporations must be certified by the state police and the FBI for capture and electronic transmissions of fingerprints.

What types of CBCs are done?

CBCs can be conducted at state and federal levels. Each contains different results and information. State CBCs will inform the BON of any crime a prospective nurse has committed in a respective jurisdiction. Federal CBCs expand the search nationwide. By using both methods, a BON will be able to assess the criminal histories of new nurse graduates, currently licensed nurses who may have misreported in the past, nurses who are requesting reinstatement for licensure and nurses who are moving from one jurisdiction to another.

What is "rap back"?

A rap back system allows for state law enforcement to automatically notify the BON of subsequent arrests of licensees whose fingerprints have been retained in a criminal history repository (Bureau of Justice Statistics, 2009). Rap back eliminates the burden of requiring licensees to resubmit fingerprints upon renewal or reinstatement of licensure.

Does having a criminal history automatically prevent an individual from obtaining a license?

In making licensure decisions, the BON will undertake a case-by-case review of the nature of the criminal history, along with other relevant factors, such as the seriousness of the crime, the amount of time that has elapsed since the person's last criminal activity and the relationship of the crime to the purposes for requiring a license to engage in the occupation, among others.

NCSBN
National Council of State Boards of Nursing

111 E. Wacker Drive, Suite 2900
Chicago, Illinois 60601-4277
312.525.3600 Phone
312.279.1032 Fax
www.ncsbn.org

References

Bureau of Justice Statistics. (n.d.). Terms & definitions: National criminal history improvement program. Retrieved April 15, 2010 from, http://bjs.ojp.usdoj.gov/index.cfm?ty=tdtp&tid=47

04/13

The Council of State Governments
Sharing capitol ideas

JULY 2013

CAPITOL FACTS & FIGURES

HEALTH

Nurse Licensure Criminal Background Checks

The role of state boards of nursing is to protect the public and ensure that those who are licensed are qualified and safe to practice. These state boards license nearly 4.2 million nurses, including licensed practical/vocational nurses, registered nurses and advanced practice registered nurses. State boards of nursing have different requirements for disclosing criminal backgrounds during their nurse licensure procedures. These include criminal background checks that may be conducted at the state or federal level, and may be based on name, Social Security number, fingerprints or by another state-specific method.

The National Council of State Boards of Nursing supports fingerprint-based criminal background checks as the most reliable method of determining whether applicants for nurse licensure have previous criminal convictions.[1]

- Thirty-six states require fingerprint-based criminal background checks.
- Of the 14 states that do not require fingerprint-based criminal background checks, five require a state record search for information on past criminal history by name checks and state court records; nine states require self-disclosure of any criminal history.
- Minnesota is the latest state to require fingerprint-based criminal background checks; it passed the requirement in May 2013.
- In many states without fingerprint-based criminal background checks, legislation has been introduced but not yet passed.

Compared with other procedures to identify past criminal convictions, fingerprint-based criminal background checks provide the most thorough information about an applicant, including convictions across state lines.

- In 2008, the Kansas legislature passed a bill requiring fingerprint screening for all nursing applicants. Fingerprinting was implemented in 2009. Since implementation, Kansas has learned that 15 percent of the applicants had a criminal history. Of those with a criminal history, 29 percent of them failed to disclose this information on their initial application.[2]
- In Texas, a study looked at the number of nurses disciplined by the board before and after the mandated fingerprint criminal background check. The study consisted of 1,508 nurses. Before the background checks, 330 nurses self-reported a criminal history. After the implementation of the fingerprint checks, within the same group, the board found 1,182 applicants with a criminal history. The difference demonstrates that criminal background checks are an effective method to uncover past crimes that were otherwise unreported. Twenty-eight percent of the crimes were felonies and 62 percent were misdemeanors.[3]
- Fingerprint-based criminal background checks connect a unique physical trait with an applicant. Without fingerprints, applicants could use an alias to hide past criminal activity.
- State-based record searches may not identify criminal convictions in the other states where the applicant has resided.

States that adopt fingerprint-based criminal background checks will need to prepare for implementation.

- In all states with fingerprint checks, the applicant bears the cost of the background check. The cost ranges from $30 to $75.[4]
- Fingerprint-based criminal background checks utilize the FBI's Integrated Automated Fingerprint Identification System. The FBI is able to crosscheck states to find criminal histories that a search of one state alone could miss.[5]
- Each state board of nursing decides how to process information returned by the FBI. In determining whether to issue a license to an applicant, the board will consider evidence-based criteria to assess whether the nurse poses a risk to the public.
- Not all applicants with a criminal history are denied licensure. Information from fingerprint-based criminal background checks provide each board of nursing information necessary to make the most informed decision.

The Council of State Governments adopted a resolution in December 2012 to support fingerprint-based criminal background checks for nurses applying for licensure. The CSG resolution recommends the policy to states because, "nurses work with the sick, disabled, elderly and other vulnerable populations, and it is in the interest of public safety to review nurse licensure applicants' past criminal behavior in determining whether they should be granted a license to practice nursing in a state or territory."[6]

Marina Byrd, CSG Research Assistant | mbyrd@csg.org
Debra Miller, CSG Director of Health Policy | dmiller@csg.org

Fingerprint-Based Criminal Background Checks for Nurse Licensure

State	Fingerprint-Based Criminal Background Checks		Comments
	Required	Not Required	Only for states not conducting fingerprint-based criminal background checks
Alabama		x	Self-Disclosure and State Records Search
Alaska	x		
Arizona	x		
Arkansas	x		
California	x		
Colorado		x	Self-Disclosure
Connecticut		x	Self-Disclosure
Delaware	x		
District of Columbia	x		
Florida	x		
Georgia	x		
Hawaii		x	Self-Disclosure
Idaho	x		
Illinois	x		
Indiana	x		
Iowa	x		
Kansas	x		
Kentucky	x		
Louisiana	x		
Maine		x	Self-Disclosure
Maryland	x		
Massachusetts		x	Self-Disclosure and State Records Search
Michigan	x		
Minnesota	x		* Legislation Passed in 2013
Mississippi	x		
Missouri	x		
Montana		x	Self-Disclosure
Nebraska		x	Self-Disclosure and State Records Search
Nevada	x		
New Hampshire	x		
New Jersey	x		
New Mexico	x		
New York		x	Self-Disclosure
North Carolina	x		
North Dakota	x		
Ohio	x		
Oklahoma	x		
Oregon	x		
Pennsylvania		x	Self-Disclosure and State Records Search
Rhode Island	x		
South Carolina	x		
South Dakota	x		
Tennessee	x		
Texas	x		
Utah	x		
Vermont		x	Self-Disclosure
Virginia		x	Self-Disclosure
Washington		x	Self-Disclosure and State Records Search
West Virginia	x		
Wisconsin		x	Self-Disclosure
Wyoming	x		

REFERENCES

[1]Information based on correspondence from the National Council of State Boards of Nursing to The Council of State Governments, May 2013.
[2]Blubaugh, MSN, RN, Mary. (2012). "Using Electronic Fingerprinting for Criminal Background Checks." Journal of Nursing Regulation, Volume 2 (Issue 4), 50-52.
[3]Texas Board of Nursing. "Study Conducted on Effectiveness of Nurse Criminal Background Checks." See: http://www.bon.texas.gov/disciplinaryaction/study-cbc.html
[4]National Council of State Boards of Nursing. "Criminal Background Checks for Nurse Licensure. Frequently Asked Questions."
[5]Blubaugh (2012).
[6]The Council of State Governments. (2012). "Resolution Supporting Criminal Background Checks for Nurses Applying for State Licensure." See: http://www.csg.org/2012NationalConference/documents/Resolution%20Supporting%20Criminal%20Background%20Checks%20for%20Nurses%20Applying%20for%20State%20Licensure.pdf

Table Source:

Information based on correspondence from The National Council of State Boards of Nursing to the Council of State Governments, May 2013.

Criminal Background Check Model Language

NCSBN	
NCSBN Model Act	**Section 9. Criminal Background Checks** Each applicant for licensure shall submit a full set of fingerprints to the BON for the purpose of obtaining a state and federal criminal records check pursuant to <state statute> and Public Law 92-544. The <state agency responsible for managing fingerprint data> may exchange this fingerprint data with the Federal Bureau of Investigation (FBI).
NCSBN Model Rules	**5.9 Criminal Background Checks** a. All individuals convicted of a sexual offense involving a minor or performing a sexual act against the will of another person shall be subject to a BON order for evaluation by a qualified expert approved by the BON. If the evaluation identifies sexual behaviors of a predatory nature the BON shall deny licensure. b. Other criminal convictions may be reviewed by the BON on a case by case basis to determine eligibility for licensure.

The Council of State Governments

RESOLUTION

THE COUNCIL OF STATE GOVERNMENTS

RESOLUTION SUPPORTING CRIMINAL BACKGROUND CHECKS FOR NURSES APPLYING FOR STATE LICENSURE

WHEREAS, nurses work with the sick, disabled, elderly and other vulnerable populations, and it is in the interest of public safety to review nurse licensure applicants' past criminal behavior in determining whether they should be granted a license to practice nursing in a state or territory;

WHEREAS, applicants for nurse licensure with criminal histories may not reveal a positive criminal history on applications, and fingerprint based background checks are an effective tool to identify past criminal behavior and ensure ongoing patient safety;

WHEREAS, of the nation's 55 boards of nursing (excluding U.S. territories), 40 boards conduct state and federal CBCs. Fifteen boards do not. This progress has been significant, but we need every state to conduct criminal background checks;

WHEREAS, boards of nursing assure the security and confidentiality of the background information and must comply with any state or federal requirements to obtain access to state criminal background checks, making this process fair to licensure applicants;

WHEREAS, Public Law 92-544 provides funding to the Federal Bureau of Investigations (FBI) for acquiring, collecting, classifying, preserving and exchanging identification records with duly authorized officials of the federal government, the states, boards of nursing, cities, and other institutions;

BE IT NOW THEREFORE RESOLVED, that the Council of State Governments urges states to conduct fingerprint based criminal background checks on all nurse licensure applicants by enacting a relevant provision in the jurisdiction's Nurse Practice Act or relevant regulations;

BE IT FURTHER RESOLVED, that The Council of State Governments recommends that states work with their boards of nursing in developing plans to conduct nurse licensure comprehensive federal and state criminal background checks.

Adopted this 3rd Day of December, 2012, at CSG's 2012 National Conference in Austin, Texas.

Does Past Criminal Behavior Predict Future Criminal Behavior?

Victoria Priola Surowiec, PsyD

Past behavior does not always predict future behavior, and all candidates with criminal histories should not be automatically denied licensure or employment as nurses. Instead, such candidates should undergo standardized psychological assessment, and a trained clinical professional should interpret the results. Integrating psychological theory and assessment into the licensure and employment decision-making process could benefit certain ex-offenders, potential employers, and society as a whole.

The notion that past behavior is a reliable predictor of future behavior seems to be widely accepted as fact. But trying to predict human behavior is complicated business, and this notion should not simply be accepted. It should be assessed and analyzed.

This article reviews a sample of the psychological literature available on this subject. The review is not intended to include everything written on the subject. Rather, it discusses key issues from a psychological perspective that may be helpful to nurse regulators as they consider licensure, reports of misconduct and disciplinary actions and to nurse managers regarding potential employment.

An understanding of the future implications of past criminal behavior from a psychological perspective can be useful to the nursing profession in that it offers a systematic, objective approach to decision making with regard to these issues. Regulators in particular can use psychological data and practices to base and substantiate their decisions for suitability on objective data and relevant research in the field. The literature clearly indicates that past behavior does not always predict future behavior, which suggests that under certain circumstances, individuals with criminal histories could be considered as candidates for a successful career in nursing.

Limitations of Predicting

Kurlychek, Brame, and Bushway (2006) point out that many organizations base their practices on the notion that past behavior predicts future behavior, citing examples from the fields of education, finance, and insurance. Specifically, Kurlychek et al. (2006) remind us that the field of education relies on an evaluation of past academic performance and standardized testing when granting entrance to college. The field of finance relies on bill-paying history and credit scores to grant a loan. The auto insurance industry keeps track of traffic tickets and accidents to determine premium rates. The authors also point out that the criminal justice system has been guided by this notion at every stage of its process, from arrest, to sentencing, to determination of parole (Kurlychek et al., 2006).

However, many factors should be considered when attempting to predict behavior, particularly criminal behavior. These factors, which interact with each other, include personality, cognition, mental illness, and general risk. Even when one considers all the factors, predicting behavior with 100% accuracy is not possible. A person may be at risk for certain behaviors, but whether or not they are acted out depends on several influences. As Andrews and Bonta (2006, p. 782) suggest:

> At any given moment, one's environment consists of a myriad of situations and ensuing choices. There may be temptations for crime in one's immediate situation as well as barriers to crime, events with emotional significance and access to non-criminal routes to obtain the same rewards as would be provided by a criminal act. The act that occurs in any given situation is a function of how the situation is defined and interpreted by the individual and the self-regulation that follows.

Role of Personality

All criminals are not alike. As Daley (1992, 1994) points out, each offender has his or her own distinct trajectory into the criminal justice system. For some, engaging in criminal acts is neither a reflection of criminal intent nor a desire to affiliate with a criminal lifestyle, but a result of a particularly distressing circumstance or mental state. By legal definition, anyone who breaks the law is considered criminal, but from a psychological perspective, not all people who have been arrested or convicted possess criminal-thinking processes or criminal personality traits. Thus, the question becomes a matter of distinguishing criminal thinkers, who have broken the law and will do so again if given

the opportunity, from noncriminal thinkers, who have broken the law but have no intention or desire to do so again.

People who will break the law again if given the opportunity likely possess traits of or the full- blown condition known as antisocial personality disorder (APD). The link between APD and criminal behavior is well established. Specifically, the *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition *(DSM IV-TR)* (American Psychological Association, 2000), a widely used manual for diagnosing mental disorders, defines APD with these criteria:

A) A pervasive pattern of disregard for the rights of others occurring since age 15, as indicated by three or more of the following:

1. failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
2. deceitfulness, as indicated by repeatedly lying, use of aliases, or conning others for personal profit or pleasure
3. impulsivity or failure to plan ahead
4. irritability and aggressiveness, as indicated by repeated physical fights or assaults
5. reckless disregard for safety of self or others
6. consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
7. lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.

B) The individual is at least 18 years of age.

C) There is evidence of Conduct disorder with onset before age 15.

D) The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or a manic episode.

People with APD are sometimes mistakenly referred to as psychopaths, but research shows that APD and psychopathy are distinct conditions (Gondolf & White, 2001). Psychopathy is a more severe form of APD. To be considered a psychopath, a person must experience a lack of remorse or guilt about his or her actions and demonstrate antisocial behaviors. According to Salekin, Rogers, Ustad, and Sewell (1998), only 15% to 30% of incarcerated offenders are psychopathic.

Still, APD is serious and accounts for a large portion of criminal offender types (Rogers, Sewell, & Cruise, 1998). In fact, studies confirm that antisocial personality traits, particularly chronic, negative affect and poor impulse control, can significantly and negatively impact the way a person perceives and interacts with the world, resulting in poor judgment and inappropriate behavior (Sevecke, Lehmkuhl, & Krischer, 2009). These people feel compelled to act out when angry, anxious, or irritable; they meet others and the world at large with tension and hostility. Furthermore, Gendreau, Little, and Goggin (1996) assert that antisocial personality traits along with a history of substance abuse and mental illness, such as schizophrenia, bipolar disorder, or major depression, increase the chance of criminal activity.

Criminal Thinking

In addition to recognizing the role of affective states, impulse control, and mental illness, cognitive content or thinking process needs to be considered. Yochelson and Samenow (1976) suggest that criminal thinking is riddled with distortions and rationalizations made during the process of engaging in criminal behavior. Furthermore, research has found that violent criminals maintain cognitions of the world as a hostile place where violence is an accepted and necessary part of life that can, over time, be perceived as having positive benefits, such as increasing one's social status (Collie, Vess, & Smith, 2007). Some of the thinking errors made by criminals include pride, failure to consider injury to others, and lack of empathy (see Yochelson & Samenow, 1976, for a complete review). Of particular interest is Gonsalvez, Scalora, and Huss's finding (2009) that in addition to believing that violence is necessary and even beneficial at times, criminals tend to be highly confident about their ability to avoid the negative consequences of their behavior, even if they have been caught before. Thus, those who are confident about avoiding consequences and consistently fail to learn from past experiences are at greater risk for criminal behavior and recidivism (Gonsalvez, Scalora, & Huss, 2009).

These findings support what is known about personality disorders, confirming the idea that criminal behavior and criminal thinking are chronic and pervasive. By definition, personality disorders are a group of mental disturbances defined by *DSM-IV-TR* as "enduring pattern[s] of inner experience and behavior" that are sufficiently rigid and deep-seated to bring a person into repeated conflicts with his or her social and occupational environment. *DSM-IV-TR* specifies that these dysfunctional patterns are regarded as nonconforming or deviant by the person's culture and cause significant emotional pain and difficulties in relationships and occupational performance. Despite the problems caused by the disorder, the thoughts and related behaviors persist. Those who meet criteria for APD or psychopathy have enduring patterns of thoughts and behaviors that cause conflicts with their environment. These people are categorized as criminal thinkers.

Predicting Recidivism and Assessing Criminality

Though recent research by Elbogen and Johnson (2009) concluded that mental illness alone does not increase the risk of violence, they found that mental illness—such as schizophrenia, bipolar disorder, or major depression—combined with substance abuse does create an increased risk. These findings are particularly relevant when considering the compromising impact an underlying

mental illness has on an offender's ability to avoid recidivism. When APD is compounded by substance abuse and the symptoms and related conditions of mental illness, an offender's ability to avoid recidivism, consciously or unconsciously, is even more severely compromised. However, not all ex-offenders suffer from a personality disorder, substance abuse, or symptoms of mental illness and psychological assessment tools can help distinguish among types of ex-offenders and assess the risk of recidivism.

The ability to assess risk for future violence and criminal acts is vitally important to society as a whole and to potential licensors and employers as they attempt to assess risk involved with ex-offenders. The field of psychology has developed tools that assess psychopathology and related cognitions and behaviors with a significant reliability and validity. Among the many assessment tools developed, a small group stands out as exceptional for assessing criminality:

- Psychological Inventory of Criminal Thinking Styles (PICTS; Walters, 1995, 2002)
- Psychopathy Checklist-Revised (PCL-R; Hare, 1991, 2003)
- Historical, Clinical and Risk Management Scales (HCR-20; Webster, Eaves, Douglas, & Wintrup, 1995; see Table 1)

Clearly, data garnered from the PICTS, PCL-R, and HCR-20 would be exceptionally helpful to nurse regulators. Other tools used to assess potential behavior include integrity tests to evaluate conscientiousness, trustworthiness, and dependability and clinical personality tests, such as the Minnesota Multiphasic Personality Inventory (MMPI), to check for serious emotional instability. All psychological tests must be administered and interpreted by a trained professional, such as a licensed clinical psychologist. Candidates also can be asked to undergo a follow-up interview during which the psychologist can elicit more information, if necessary. The cost of these tests varies, depending on the fees of the psychologist. Some organizations hire a psychologist from a private firm or testing company; others have trained clinical personnel on staff.

TABLE 1

Best Tools for Assessing Criminality

The **Psychological Inventory of Criminal Thinking Styles** (PICTS) is a well-researched instrument designed to examine criminal thinking styles considered "instrumental in protecting and maintaining a criminal lifestyle" (Walters, 2002, p. 278). Gonsalvez, Scalora, and Huss (2009) point out that this instrument is particularly useful because it "taps into different cognitive processes associated with criminal behavior" (p. 742). Further research has shown that the PICTS is also useful in predicting recidivism (Gonsalvez, Scalora & Huss, 2009; Walters, 2010), indicating a strong link between criminal thinking patterns and the outcome of criminal behavior.

However, when the PICTS is used alone to predict recidivism, it does have limitations. Specifically, "the PICTS does not incorporate any behavioral items and therefore, to improve the prediction of recidivism, a combination of cognitive and behavioral measures may be more useful" (Gonsalvez et al., 2009, p. 743). Consequently, the authors recommend using the PICTS with the **Psychopathy Checklist-Revised** (PCL-R; Hare, 2003) to improve prediction capabilities. The PCL-R is also a well-researched, widely used tool designed to measure the two components of psychopathy: personality and behavior. Numerous studies have found it to be a strong predictor of recidivism (Salekin, Rogers, Ustad, & Sewell, 1998; Walters, 2006). Gonsalvez et al. (2009) found that, when used together, the PICTS and the PCL-R are reliable tools for identifying criminal thinking and predicting recidivism.

The usefulness of the **Historical, Clinical and Risk Management Scales** (HCR-20) as a predictor of violent behavior has been demonstrated in a number of studies (Douglas, Ogloff, Nicholls, & Grant, 1999; Douglas & Webster, 1999; Grann, Belfrage, & Tengstrom, 2000; Strand, Belfrage, Fransson, & Levander, 1998). The HCR-20 was designed to evaluate clinical state as well as effectiveness of risk management strategies. Research revealed that the tool has a significant predictive ability, specifically in determining violent recidivism with mentally disordered populations (Gray et al., 2003).

Legal Issues Related to Testing and Employment Decisions

The tests mentioned above, including the PICTS, PCL-R, HCR-20, and MMPI, have been validated and are considered scientifically sound, and their results can be used as evidence in court proceedings (Moss, 2008). However, a host of legal issues must be considered when testing potential or current students or employees. The most significant arise from Title VII of the Civil Rights Act of 1964, and the Americans with Disabilities Act of 1990. The Civil Rights Act clearly states that it is unlawful for employers to use any pre-employment tool that has a substantially negative impact on a protected subgroup, such as an individual of a particular race or gender, unless the tool can be shown to be job-related and consistent with business necessity. Tools that do have an adverse impact must be justified by validity evidence. Courts will judge on a case-by-case basis whether tests with a disparate impact can be used for employment purposes. They will weigh whether an invasive test is justified by appropriate business or societal interests in a given situation. According to the National Association of Professional Background Screeners (Moss, 2008), as a general rule, invasive instruments such as clinical personality tests are most likely to be justified when screening for safety-sensitive positions such as nursing. Clinical personality and integrity tests have consistently been shown not to have an adverse impact on a particular subgroup. In fact, personality and integrity tests have had an excellent record when subjected to civil rights claims.

Well-developed personality and integrity tests can be effective, objective, and fair in helping regulators handle misconduct,

determine disciplinary actions and develop policy. Should the nursing profession adopt the use of testing, the tests must be used appropriately and in a manner consistent with legal standards.

Collateral Consequence

Although people with criminal histories are more likely to offend in the future, the risk of re-offending declines as time passes. For example, Schmidt and Witte (1988) found with their forensic sample that recidivism rates began to approach zero after 5 years of follow-up. Furthermore, analysis of data on offenders from adolescence to age 70 shows that most offenders do desist, with the bulk of offenders not experiencing additional arrests after age 40 (Blokland, Nagin, & Nieuwbeerta, 2005; Laub & Sampson, 2003). The literature clearly suggests that the longer a person goes without re-offending, the more likely it is that he or she will not re-offend.

With that being said, the issue of *collateral consequence* needs to be raised. This legal term is used to describe legal restrictions placed on employing ex-offenders in certain types of jobs. Kurlychek et al. (2006) express concern for the ethics of collateral consequence, suggesting "they amplify punishment beyond the sanctions imposed by the criminal justice system" (p. 1102). This issue is particularly relevant to nursing because nurses are entrusted with the duty of taking care of people when they are often at their most vulnerable. And so the general question must be asked: Should people with criminal histories of any type be banned for life from careers in nursing? More specifically, if a person has a criminal history but does not suffer from a personality disorder, use criminal thinking, or have any risk factors, should he or she not be banned from a career in nursing?

Summary

The data presented suggest that the nursing profession should approach these questions in a manner similar to that used by the court system: Decisions should be made on a case-by-case basis. Further, decisions about hiring, misconduct, discipline, and policy should be based on objective, standardized data garnered from results of reliable and valid psychological testing that is recognized by the courts as such. Interpreting criminal justice information and determining its relevance without experienced assistance from trained professionals can be problematic and unfair. Instead, trained professionals should be used to assess ex-offenders. Along with considering the results from psychological tests, additional information should be considered, such as the length of time since the last offense on record and the nature and gravity of the offense, to aid their decision-making processes (SEARCH, 2005).

This article illustrates that past behavior does not always predict future behavior. Nurse regulators and managers can be given wide discretion to make decisions about the relevance of the criminal justice record, but they do not have to automatically deny licensure or employment because a record exists. Instead, interested candidates with criminal histories should undergo standardized psychological assessment and, under the scrutiny of a trained clinical professional, the objective results of the tests should be used to determine an individual's appropriateness for nursing duty. Much could be gained by ex-offenders, potential employers, and society at large, if psychological theory and assessment were integrated into the decision-making process in an effort to give those who sincerely want it, a second chance in life.

References

American Psychological Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychological Association.

Andrews, D. A., & Bonta, J. (2006). *The psychology of criminal conduct* (4th ed.). Newark, NJ: LexisNexis/Mathew Bender.

Blokland, A., Nagin, D. S. & Nieubeerta, P. (2005). Life span offending trajectories of a Dutch conviction cohort. *Criminology 43,* 919–954.

Collie, R. M., Vess, J., & Smith, P. (2002). Violence-related cognition: Current research. In T.A. Gannon, T. Ward, A. R. Beech, & D. Fisher (Eds). *Aggressive offenders' cognition* (pp. 179–198). West Sussex, UK: Wiley.

Daley, K. (1992). Women's pathways to felony court: Feminist theories of law-breaking and problems of representation. *Southern California Review of Law and Women's Studies, 2,* 11–52.

Daley, K. (1994). *Gender, crime and punishment*. New Haven, CT: Yale University Press.

Douglas, K. S., Ogloff, J. R. P., Nicholls, T. L., & Grant, I. (1999). Assessing risk for violence among psychiatric patients: The HCR-20 violence risk assessment scheme and the Psychopathy Checklist: Screening Version. *Journal of Consulting and Clinical Psychology, 67,* 917–930.

Douglas, K. S., & Webster, C. D. (1999). The HCR-20 violence risk assessment scheme: Concurrent validity in a sample of incarcerated offenders. *Criminal Justice and Behaviour, 26,* 3–19.

Elbogen, E. B., & Johnson, S. C. (2009). The intricate link between violence and mental disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry, 66*(2), 152–161.

Gendreau, P., Little, T., & Goggin, C. (1996). A meta-analysis of the predictors of adult offender recidivism: What works! *Criminology, 34,* 575–607.

Gondolf, E. W. & White, R. J. (2001). Batterer program participants who repeatedly reassault: Psychopathic tendencies and other disorders. *Journal of Interpersonal Violence, 16*, 361–380.

Gonsalves,V. M., Scalora, M. J., & Huss, M. T. (2009). Prediction of recidivism using the Psychopathy Checklist-Revised and the Psychological Inventory of Criminal Thinking Styles within a forensic sample. *Criminal Justice and Behavior, 36,* 741–756.

Grann, M., Belfrage, H., & Tengstrom, A. (2000). Actuarial assessment of risk for violence. Predictive validity of the VRAG and the historical part of the HCR-20. *Criminal Justice and Behaviour, 27,* 97–114.

Gray, N. S., Hill, C., McGleish, A., Timmons, D., MacCulloch, M. J., & Snowden, R. J. (2003). Prediction of violence and self-harm in mentally disordered offenders: A prospective study of the efficacy of the HCR-20, PCL-R and psychiatric symptomatology. *Journal of Consulting and Clinical Psychology, 71*(3), 443–451.

Hare, R. D. (2003). *The Hare psychopathy checklist-revised* (2nd ed.). Toronto: Multi-Health Systems.

Kurlychek, M. C., Brame, R., & Bushway, S. D. (2006). Scarlet letters and recidivism: Does an old criminal record predict future offending? *Criminal Justice and Behavior, 5*(3), 1101–1122.

Laub, J. H., & Sampson, R. J. (2003). *Shared beginnings, divergent lives: Delinquent boys to age 70.* Cambridge, MA: Harvard University Press.

Moss, T. (2008). Who the devil is applying now? Your guide to employment testing. Retrieved from http://www.crimcheck.com/background-check/employment-testing.htm

Rogers, R., Sewell, K. W., & Cruise, K. R. (1998). The PAI and feigning: A cautionary note on its use in forensic correctional settings. *Assessment, 5,* 399–405.

Salekin, R. T., Rogers, R., Ustad, K. L., & Sewell, K. W. (1998). Psychopathy and recidivism among female inmates. *Law and Human Behavior, 22,* 109–128.

Schmidt, P., & Witte, A. D. (1988). *Predicting recidivism using survival models*. New York: Springer-Verlag.

SEARCH Group, Inc. (2005). *Report on the National Task Force on the Commercial Sale of Criminal Justice Record Information.* Sacramento, CA: SEARCH Group, Inc.

Sevecke, K., Lehmkuhl, G., & Krischer, M. K. (2009). Examining relations between psychopathology and psychopathy dimensions among adolescent female and male offenders. *European Child and Adolescent Psychiatry, 18,* 85–95.

Strand, S., Belfrage, H., Fransson, G., & Levander, S. (1998). Clinical and risk management factors in risk prediction of mentally disordered offenders—More important than actuarial data? A retrospective study of 40 mentally disordered offenders assessed with the HCR-20 violence risk assessment scheme. *Legal and Criminological Psychology, 4,* 67–76.

Walters, G. D. (2006). Effect of test administration set on the Psychological Inventory of Criminal Thinking Styles (PICTS). I*nternational Journal of Offender Therapy and Comparative Criminology, 50*(6), 661–671.

Walters, G. D. (2010). Predicting recidivism with the Psychological Inventory of Criminal Thinking Styles and Level of Service Inventory-Revised: Screening version. *Law and Human Behavior,* May 13.

Walters, G. D. (1995). The Psychological Inventory of Criminal Thinking Styles: Part I. Reliability and preliminary validity. *Criminal Justice and Behavior, 22,* 307–325.

Walters, G. D. (2002). The Psychological Inventory of Criminal Thinking Styles (PICTS): A review and meta-analysis. *Assessment, 9*(3), 278–291.

Webster, C. D., Eaves, D., Douglas, K. S., & Wintrup, A. (1995). The HCR-20 scheme: The assessment of dangerousness and risk. Vancouver, Canada: Simon Fraser University and Forensic Psychiatric Services Commission of British Columbia.

Yochelson, S., & Samenow, S. E. (1976). *The criminal personality: A profile for change.* New York, NY: Jason Aronson.

Victoria Priola Surowiec, PsyD, is Chair of the Police and Forensic Psychology Program and a core faculty member at the Adler School of Professional Psychology in Chicago, Illinois.

Using Electronic Fingerprinting for Criminal Background Checks

Mary Blubaugh, MSN, RN

Because state background checks revealed an increasing number of licensure applicants with criminal records, the Kansas Board of Nursing (BON) instructed its staff to research the problem. In 2005, the BON voted to introduce legislation requiring a background check for nurse licensure. At the same time, the BON was challenged to determine the best process for screening applicants. In 2008, the Kansas legislature passed a bill implementing a criminal background history and Federal Bureau of Investigation screening for all initial applicants for nursing and mental health technicians. At the same time, the board made the decision that this background check would be implemented using live scan fingerprint technology.

In 2003, the Kansas Board of Nursing (BON) dealt with a case in which a convicted felon stole a registered nurse's identity, including his license to practice. Around the same time, the number of applicants with criminal records discovered during state background checks was increasing. In response, the BON instructed its staff to research the problem and draft language for a possible statute change requiring federal and state criminal background checks for licensure, using the best possible process. In 2008, a bill implementing a criminal background history and Federal Bureau of Investigation (FBI) fingerprint screening using live scan fingerprint technology for all initial applicants for nursing and mental health technicians passed the Kansas legislature. This article describes the process, challenges, and outcomes.

Background Checks for Public Protection

Nurses care for vulnerable people and have access to their personal information. "Nurses are placed in a position of public trust" (National Council of State Boards of Nursing [NCSBN], 2005). Because of this, nurses are held to a higher standard, and BONs have responsibility for protecting the public health and safety of the citizens in their state.

The California BON was the first to require criminal background checks for initial licensure. In 1998, only five BONs were authorized to collect fingerprints. By 2005, 18 states required fingerprints for FBI background checks for licensure (NCSBN, 2005).

In 2004, the Centers for Medicare & Medicaid Services conducted a pilot program with seven states to create background check programs for workers in long-term care environments. The program required screening through state and federal fingerprint databases. Because no database is complete, the best practice is to use state-based registries and FBI records. In the pilot program, FBI checks identified applicants with a criminal history missed by the state check. The pilot program, which lasted 3 years, was successful, and the seven participating states continued using the background check process (Senate Special Committee on Aging, 2008).

At the 2005 annual meeting of the National Council of State Boards of Nursing (NCSBN), delegates voted to approve the five recommendations of the Disciplinary Resource Advisory Panel, which included a recommendation to use criminal background checks on applicants for licensure (NCSBN, 2005).

At their December 4, 2005 meeting, the Council of State Governments Intergovernmental Affairs Committee adopted a resolution supporting criminal background checks for nurses applying for state licensure and urged states to use criminal background checks for all nurse licensure applicants. The committee suggested that states work with their BONs to develop plans for national criminal background checks. The committee also posed several policy questions: How to assess current workload and resources, which questions were needed on licensure applications, when criminal background checks should be implemented, whether a temporary permit should be issued before receiving a rap sheet, what the policy would be for nonreadable fingerprints, and what the appeal process for an applicant would be (Council of State Governments Intergovernmental Affairs Committee, 2005).

Background-Check Tools

"For many years, fingerprints have played an invaluable role in criminal and investigative work. For centuries, man has utilized various systems of identification such as branding, tattooing, distinctive clothing, photography, and measurement. These systems, without exception, have not produced completely desirable results. Only fingerprinting, of all methods of identification, has

proved to be both infallible and feasible" (Collins, 1991, p. 2). Fingerprints have become more common since World War II, and numerous court decisions support their use as evidence and identification (Fingering fingerprints, 2000). An effective way to identify those with a history of crime is to use state and federal background checks (Senate Special Committee on Aging, 2008). The Integrated Automated Fingerprint Identification System, maintained by the FBI, is the largest database of criminals in the world. The FBI Identification Record (rap sheet) is a snapshot of a person's history at the time a background check report is issued (Federal Bureau of Investigation [FBI], n.d.).

For those not representing law enforcement or the courts, the FBI requires statutory authority to access the FBI database. The FBI requires certain elements to be placed in the state statute that include legislative enactment, fingerprint-based criminal background check, submission of fingerprints to the state identification bureau, categories of licensees for background checks, and an authorized government agency to be the recipient of the rap sheet (FBI, n.d.).

Fingerprints can be obtained using a fingerprint card or a live scan. A fingerprint card uses ink to print images on the fingerprint card. A live scan collects fingerprints using a scanning device and allows electronic submission to the appropriate authorities. The live scan fingerprint technology decreases errors and makes processing quicker (Senate Special Committee on Aging, 2008). In addition, a rap back system can automatically push any crime committed after the initial fingerprinting to the person's rap sheet and report the new information to licensing agencies. The federal government is currently working on a federal rap back system (Senate Special Committee on Aging, 2008).

Legislative Process in Kansas

In 2005, the Kansas BON voted to introduce legislation requiring a background check for licensure. The BON staff and the Kansas Bureau of Investigation (KBI) worked together to develop language that was sent to the FBI for approval. During the 2006 legislative session, the language was introduced in the Health and Human Services Committee of the Kansas House of Representatives, but no action was taken in that session.

During the 2007 legislative session, the language was introduced in the Kansas Senate Public Health and Welfare Committee. The BON was successful in amending House Bill 2620 to include the implementation of criminal background history and FBI fingerprint screening for all initial applicants for nursing and mental health technicians. The bill passed the Kansas legislature and was signed by then Governor Kathleen Sebelius on May 14, 2008, with the effective date of July 1, 2008.

Implementation in Kansas

Interviews were conducted with staff members of other state BONs that implemented background checks to determine the processes used and difficulties encountered during implementation. One issue for several staff members was the amount of time between submitting fingerprint cards and receiving the rap sheets. Texas reported a 12% rejection rate for poor-quality fingerprint cards. In these cases, the applicants were fingerprinted a second time, and the new card was submitted. These rejections increased applicants' waiting time and the BON's costs (Texas Board of Nursing). The Florida BON reported a rejected fingerprint card could add 6 to 8 weeks to the licensure process (Pouncey, 2008).

The Kansas BON and the KBI met several times during the implementation process, developing a collaborative relationship. These meetings included the administration, information technology (IT), and legal divisions of both agencies. Meeting topics included resources, software, electronic fingerprints, rap back systems, IT connections, and concerns about unreadable fingerprint cards and the time needed to receive rap sheets.

During one meeting, the KBI demonstrated a live scan developed by Sagem Morpho and discussed the pros and cons of electronic fingerprinting. The pros included decreased time for receiving rap sheets, more accurate fingerprints, and a decreased number of unreadable fingerprints. The cons included the cost of the equipment, the need to input demographic information manually, and storage of the equipment.

The Kansas BON signed a memorandum of agreement on the dissemination of criminal history information, stating that the KBI would act as the vendor for the BON and would coordinate fingerprint results with the FBI. The BON was developing new licensing software, and the fingerprints requirement was incorporated into the new software.

The BON staff determined that purchasing the live scan equipment would benefit the BON and future applicants because of the quickness and accuracy compared with the paper-based inked fingerprints. A list of approved state and KBI contract vendors for live scan was reviewed, and the Sagem Morpho live scan was selected. However, unforeseen cuts to the BON's budget derailed the equipment purchases.

Fortunately, the NCSBN received the Office for the Advancement of Telehealth Licensure Portability Grant, and part of the grant went toward helping state BONs implement criminal background checks. The Kansas BON requested a $50,000 grant to implement the criminal background bill that included FBI fingerprint screening as a licensing requirement. The request included the development of new software, the purchase of two 1000-ppi mobile live scan machines, annual maintenance, and staff training time. The BON chose mobile units over nonmobile units because it planned to conduct fingerprint processing at student nurse functions.

After receiving the grant, the BON ordered the live scan machines and developed new application forms and procedures. Procedures were drafted and approved by the Kansas BON on September 17, 2008. A workshop conducted for nursing school administrators on September 15, 2008, included requirements and procedures for fingerprints. The public, health facilities, and nurses were notified using the BON's website, Twitter, Facebook, and quarterly newsletter.

Before taking delivery of the equipment, the BON was required to develop a segmented dedicated secure network with the KBI. This network created a site-to-site firewall connection for criminal background checks transmissions. The BON also was required to install dedicated network LAN ports to connect to the data center's firewall.

After receiving the two mobile live scan machines, 10 staff members participated in a half-day training session on using them. Staff members worked directly with the KBI to ensure the quality of the fingerprint process.

Outcomes and Efficacy

The work duties of the licensing clerks were reviewed, and new duties and processes were incorporated by the existing staff. Fingerprinting for licensure was implemented on July 1, 2009, and live scan was implemented on August 25, 2009. Since implementation, the BON has processed 11,846 fingerprints, and 1,724 of the applicants had a criminal history (14.5%). Of those with criminals histories, 1,273 were nursing students seeking licensure, and 371 (29%) of them had a criminal history that was not disclosed on their initial application.

The BON staff has conducted 1,311 live scans since implementation and receives live scan rap sheets 24 to 48 hours after submission. Receiving a rap sheet takes 5 to 7 days after submitting an inked fingerprint card. If a name check is required because of an unreadable fingerprint, the staff receives the rap sheet in 4 to 6 weeks.

The live scan devices have obtained fingerprints of nursing students at various nursing schools and conferences. During a 1-day conference, 75 nursing students were fingerprinted. Two local nursing schools send their students to the BON office for fingerprinting.

One of many background-check success stories involves a nursing school graduate who submitted an application for licensure. The background check revealed that the applicant had five drug and alcohol convictions. The name on the convictions did not match the name the graduate put on the licensure application. Only a high-tech background check could have revealed these convictions.

Background checks are an effective tool to identify individuals with criminal histories. Federal criminal history checks through the FBI's Integrated Automated Fingerprint Identification System identify individuals with any arrests or convictions. Live scan fingerprint technology produces quicker reports and less chance of error than paper-based inked fingerprints.

References

Collins, C. G. (1991). Fingerprint science: How to roll, classify, file and use fingerprints. Placerville, CA. Custom Publishing.

Council of State Governments Intergovernmental Affairs Committee. (2005). Resolution supporting criminal background checks for nurses applying for state licensure. Retrieved from www.csg.org/knowledgecenter/docs/ChecksNurses.pdf

Federal Bureau of Investigation. (n.d.). Identification record request/criminal background check. Retrieved from www.fbi.gov/about-us/cjis/background-checks/background_checks

Fingering fingerprints. (2000). The Economist, 357(8021), 89. Retrieved from www.economist.com/node/449298

National Council of State Boards of Nursing. (2005). Mission possible: Building a safer nursing workforce through regulatory excellence. Chicago, IL: Author.

Pouncey, L. (2008). Electronic fingerprinting project. Retrieved from https://interactive.ncsbn.org/iportal/default.aspx?tabid=306

Senate Special Committee on Aging. (2008). Building on success: Lessons learned from the federal background check pilot program for long-term care workers. Retrieved from aging.senate.gov/letters/bcreportexecsummary.pdf

Texas Board of Nursing. (n.d.). Proposal to conduct random criminal background checks on currently licensed nurses. Presented at National Council of State Boards of Nursing IT summit. Presentation by the Texas Board of Nursing.

Mary Blubaugh, MSN, RN, is the Executive Administrator at the Kansas State Board of Nursing.

Prelicensure RN Students With and Without Criminal Histories: A Comparative Analysis

Danielle Smith, MSN, RN; Shana Corvers, PhD; William J. Wilson, MS; Dominique Douglas, MS; and Cynthia Bienemy, PhD, RN

The purpose of this study was to determine whether certain key outcomes differ between preRN licensure students who have a criminal history and those who do not. Outcomes examined were program completion, NCLEX-RN® passage, subsequent criminal acts, and subsequent professional misconduct. A retrospective descriptive-comparative research design was used. The sample consisted of 3,166 applicants from the 2006 cohort of preRN licensure students in Louisiana who met the criteria for inclusion in the study. Analysis of the data revealed 10% of participants with a criminal history had a subsequent criminal incident, whereas only 3.4% of the noncriminal history group had a subsequent criminal incident. Additionally, 4.5% of the criminal history group had subsequent professional misconduct compared with 1% of the noncriminal history group.

In Louisiana, the board of nursing (BON) has jurisdiction over a nursing student's entry into clinical practice, and a student applicant is subject to the same process as a registered nurse (RN) applicant, including a criminal history record information check. Before 2005, the Louisiana BON relied on a student's self-disclosure of criminal history on application (Moody, 2010). However, criminal record checks conducted on applications for initial licensure by examination discovered that many students failed to disclose arrests and charges ranging from driving under the influence (DUI) to distribution of drugs (B. L. Morvant, personal communication, November 4, 2010). Thus, in 2005 the BON began requiring a criminal background check (CBC) on students before enrollment in the first clinical nursing course (Criminal History Record Information, 2005). Applicants complete the CBC form as part of their application to the prelicensure nursing program; the program submits the forms to the BON for review.

Because the Louisiana BON is concerned with the underlying conduct involved in the criminal matter and not just the final adjudication, the investigation of a student's criminal history is complex and time-consuming. The BON staff frequently encounters student applicants with criminal incidents ranging from possession of illegal drugs to identity theft. Few crimes result in permanent denial of clinical entry because denial is reserved for the most serious felonies, usually those involving violence or drug distribution. In 2011, the BON approved 4,005 applications for clinical enrollment; 1,034 were placed under investigation; 59 were delayed; and only 14 were denied (Louisiana State Board of Nursing [LSBN], 2011, p. 23).

According to the American Association of Colleges of Nursing (AACN; 2011), approximately 68,000 *qualified* nursing applicants were turned away from baccalaureate and graduate programs in 2010. Louisiana's nursing schools were not able to accommodate 1,453 undergraduate nursing students in 2011 (LSBN, 2011, p. 71).

The study presented here may provide schools of nursing with information to refine admission criteria or perhaps support the use of CBCs to better utilize limited enrollment. Since 2005, the National Council of State Boards of Nursing has postulated that the focus is no longer on whether or not to conduct CBCs, but how best to use criminal histories for licensure decisions. This study will help Louisiana and possibly other regulators and educators begin to answer this question before eligibility for licensure.

The research questions for the study were:

- Does the rate of program completion differ between the criminal history group and the noncriminal history group?
- Do the NCLEX-RN® passage rates differ between the two groups?
- Does the rate of criminal behavior after initial approval to enter clinical nursing courses differ between the groups?
- Does the rate of professional misconduct after initial approval to enter clinical nursing courses differ between the groups?

Literature Review

This review focuses on the research most relevant to the student nurse population. The scarcity of research related to student

criminal history and subsequent professional misconduct underscores the need for research of this type.

A review of the literature using combinations of the keywords—criminal background check, criminal histories, nursing school admission criteria, criminal history, substance abuse and recidivism, criminal, nursing students, disciplinary actions, professional misconduct, and criminal behavior—revealed four major areas of interest. First, several publications addressed the importance of conducting CBCs on all nurses to ensure public safety. Second, the review revealed information on performing CBCs on students. Third, the literature was replete with articles discussing criminal behavior, substance abuse, and recidivism, although not specific to professionals. Finally, a small number of studies examined the characteristics of individuals who committed professional misconduct.

Criminal Background Checks

Several articles referenced the 2001 Joint Commission requirement for hospitals to perform CBCs on staff, health care students rotating through the facility, and volunteers when mandated by state law and organizational policy as a driving force to perform CBCs on students (Berry, 2010; Farnsworth & Springer, 2006; Jones & Weninger, 2007; Moody, 2010; Smith, 2007). Farnsworth and Springer (2006) cite three reasons nursing schools are being pressured to conduct criminal record checks. First, even when not mandated by state law, health care facilities may require background checks on students before beginning a clinical rotation. Second, before completion of the nursing program, the CBC should be used to determine eligibility for licensure. Third, some schools believe "it is in the best interest of the public to have the backgrounds of their students investigated" (p. 148). Even with increasing pressure, many schools are not performing CBCs because no clear guidelines exist on what to do with the results and because some programs are unable to deny a student who has a criminal history if he or she is academically qualified.

Criminal Behavior and Recidivism

Kurlychek, Brame, and Bushway (2006) designed research to determine if distant criminal records predict recidivism. The authors cite U.S. Department of Justice statistics that indicate two-thirds of convicts released from prison commit another criminal act or parole violation within 3 years of release. However, with the passage of time, most criminals desist and commit few crimes after age 40. The researchers found that if 6 or 7 years have lapsed since the last offense, the rate of criminal acts is similar to the rate for persons with no criminal record.

Surowiec (2010) looks beyond past criminal behavior as the sole predictor of recidivism and emphasizes the importance of criminal thinking and personality as a better indicator of future criminal behavior. She asserts that all individuals who commit crimes are not criminals. Only those who possess criminal-thinking styles, such as antisocial personality disorder, are likely to continue criminal patterns. The author recommends the use of standardized psychological testing to assist regulatory boards in making licensure decisions for individuals with criminal histories.

The study conducted by Stasiewicz, Nochajski, and Homish (2007) is particularly relevant to the student population because DUI is one of the most common alcohol-related behaviors among college students (Clapp et al., 2005). The researchers looked at 549 convicted DUI offenders and found that repeat offenders (n = 161) were twice as likely to suffer from alcohol use disorders. Additionally, the males in this sample were twice as likely as the females to have more than one DUI. This research supports the need for effective evaluations for repeat DUI offenders to determine if an ongoing substance use disorder exists.

Professional Misconduct and Disciplinary Action

In 2009, a study conducted by Zhong, Kenward, Sheets, Doherty, and Gross found a significant correlation between a nurse's criminal conviction history and subsequent BON disciplinary action. The researchers chose to exclude disciplinary cases involving substance abuse if there was no patient involvement. This seems particularly significant because Clevette, Erbin-Roesemann, and Kelly (2007) found substance abuse/controlled substance violations to be the most common cause of disciplinary action.

Method

A retrospective descriptive-comparative research design was used for the study.

Subjects

All students with a CBC form received and acted upon by the BON between January 1, 2006, and December 31, 2006, were determined eligible for inclusion in the study. Formal action included approval, approval with stipulations, delay, and denial.

A total of 3,469 applications were reviewed; 303 applications were excluded, resulting in a final study population of 3,166. Participants were excluded for reasons including attendance at an out-of-state school at the time of application, failure to apply for initial RN licensure in Louisiana, and incomplete student files. Of the 3,166 study participants, 467 (14.7%) had a criminal history, and 2,699 (85.3%) did not.

Instrument Development

Approximately 200 applications were reviewed using the individual student files and demographic and licensure information contained in the database used by the BON (Nurse Track®) to develop the data abstraction instrument used to obtain information for analysis. During this sampling review, codes and algorithms were devised to allow for accurate extraction of the data from Nurse Track and the student files.

TABLE 1

Demographic Characteristics of the Reduced Sample

Variables	Criminal History	Noncriminal History
Sex	Female: 73% Male: 27%	Female: 73% Male: 27%
Race	White: 64% Black: 31% Other: 5%	White: 64% Black: 31% Other: 5%
Average age (years)*	36	32
Degree sought	Baccalaureate: 44% Associate: 53% Diploma: 3%	Baccalaureate: 51% Associate: 46% Diploma: 4%

*Age is rounded.

Data collectors were trained using the data abstraction instrument. One data abstraction instrument was used to collect data on one applicant. Data collectors were monitored, and periodic checks were conducted throughout the data collection process.

Two data collectors used the data abstraction instrument once to abstract data from the same data source, and the two sets of results were compared to determine the inter-rater reliability for the data abstraction instrument. A 95% agreement rate between the two data collectors was deemed acceptable and was achieved.

Procedure for Data Collection

Applicants meeting the inclusion criteria were divided into two cohorts: applicants with a criminal history and applicants without a criminal history.

The data abstraction instrument allowed for manual extraction of data from the following sources: the 2006 application for admission to a preRN licensure program, the application for initial RN licensure by examination, the Louisiana BON website's Licensure Verification, Nursys®, and Nurse Track.

Following data abstraction and verification, data were entered into a Microsoft Access database in preparation for analysis. To increase the accuracy of the data entry process, the double data entry method was used to verify data prior to analysis. Two data collectors entered the same data into two separate Microsoft Excel spreadsheets. The two spreadsheets were compared for differences and corrections were made after referring to the original data abstraction tool. Data were then uploaded into Microsoft Access for analysis.

To protect the study participants' identities, a unique identifier was assigned to each data abstraction instrument, which served as the only link to the applicant. No item of information that would enable the identification of the applicant was recorded, and the study reports only aggregated data.

Data Analysis Results

Because of the large difference in the number of participants in the noncriminal history group (n = 2,699) and the criminal history group (n = 467), a reduced matched sample based on race and gender was used. The intent was to use a matched-pair cohort for comparison analysis, by closely matching variables from both the criminal and noncriminal history groups. The goal was to reduce bias and focus on similarities of variables as well as equal the sample size in both groups. The matched sample consisted of 465 criminal history applicants (N = 465 or 50%) and 465 noncriminal history applicants (N = 465 or 50%). Of the 467 applicants with criminal histories (N = 465 in the matched sample), 70% had just one criminal event; 16% had two criminal events; 5% had three criminal events; and 9% had more than three criminal events. Of the 930 participant records in the reduced sample, 92.1% (n = 859) were approved for entry into clinical courses; 41 (4.4%) were approved with sanctions; 18 (1.9%) were delayed; and 15 (1.6%) were denied. Table 1 provides a descriptive statistical analysis of the demographic profile of the reduced sample.

A review of the findings for each research question follows.

Does the Rate of Program Completion Differ Between the Two Groups?

In the full population, 68% of those with a criminal history graduated from the nursing program compared with 72% of the noncriminal group. In the matched sample, 71% of the criminal history group graduated from the nursing program compared with 72% of the noncriminal group. Statistical analysis yielded no significant difference between the two groups. Chi square test (df = 1) yielded a Chi square test value of X^2 = .0241 with a probability .876.

Do the NCLEX-RN Passage Rates Differ Between the Two Groups?

For this analysis, only students who graduated were included. In the full sample, 98.4% of the criminal history group passed the NCLEX–RN compared with 99.4% of the noncriminal history group. In the matched sample, 92.3% of the criminal history group passed the NCLEX–RN compared with 95.8% of the noncriminal group. Statistical analysis yielded no significant difference between the two groups. Chi square test (df = 2) yielded a Chi square test value of X^2 = 2.91with a probability .0232.

Does the rate of Criminal Behavior After Initial Approval to Enter Clinical Nursing Courses Differ Between the Groups?

In the full sample, 10% of the criminal history group had subsequent criminal activity compared with 2.3% of the noncriminal history group. In the matched sample, 10% of the criminal history group had subsequent criminal activity compared with 3.4% of the noncriminal history group. Nearly three times as

many participants in the criminal history group had subsequent crimes (n = 47) than those in the noncriminal history group (n = 16). Statistical analysis yielded a significant difference between the two groups. Chi square test (df = 1) yielded a Chi square test value of X^2 = 11.064 with a probability .0009.

Does the Rate of Professional Misconduct After Initial Approval to Enter Clinical Nursing Courses Differ Between the Groups?

Those with a criminal history were more likely to incur subsequent professional misconduct after receiving approval to enter clinical courses. In both the full and the matched samples, 4.5% of those with a criminal history had a record of professional misconduct compared with 1% of those with a noncriminal history. In the matched sample, 4 individuals with no criminal history had subsequent disciplinary or nonpublic action, and 21 individuals with a criminal history had subsequent disciplinary or nonpublic action. Some had more than one action against them, explaining 33 total actions against 21 individuals. Statistical analysis yielded a significant difference between the two groups. Chi square test (df = 1) yielded a Chi square test value of X^2 = 9.71 with a probability .045.

Other Findings

In both samples, those with criminal histories were more likely than those without a criminal history to incur subsequent disciplinary or nonpublic actions, such as confidential participation in the recovering nurse program and confidential monitoring agreements. In the full and reduced samples, the most common actions among those with criminal histories were probation during nursing school (n = 6) and automatic suspension from clinicals for violating a BON order (n = 10). For those with a noncriminal history, probation during nursing school (n = 2) and auto-suspension of license for violating a BON order (n = 3) were the most common actions taken by the BON for professional misconduct.

Approximately 18.2% of those with a criminal history did not disclose it. Of the 85 participants in the criminal history group who did not disclose their history, 10 (11.7%) had a subsequent criminal incident. Of the 370 that did disclose their history, 37 (10%) had a subsequent criminal incident. Disclosure does not appear to make a difference in subsequent criminal activity.

TABLE 2

Summary of Research Questions and Conclusions

Research Questions	Conclusion
Does the rate of program completion differ between the two groups?	No
Do the NCLEX-RN® passage rates differ between the two groups?	No
Does the rate of criminal behavior after initial approval to enter clinical nursing courses differ between the groups?	Yes
Does the rate of professional misconduct after initial approval to enter clinical nursing courses differ between the groups?	Yes

Discussion

As noted, no significant differences existed between the two groups regarding the rates of nursing program completion and NCLEX-RN passage. (See Table 2.) However, differences did exist regarding the rates of subsequent criminal activity and professional misconduct. Participants with criminal activity in more than one crime category were more likely to engage in subsequent professional misconduct. A longitudinal study of this population in 5 or 10 years would be useful to determine if the trend continues. Additionally, because Clevette et al. (2007) found that professional misconduct occurred earlier for those with a criminal history compared to those without a criminal history, studying this population at intervals would allow testing of this finding.

The characteristics of the population supported the findings in the literature. For example, though males constituted 13.5% of the study population, they represented 26.6% of the applicants with a criminal history. Despite knowing that a CBC was to be conducted, 18.2% of the criminal history group failed to disclose a criminal history. This finding underscores the importance of conducting CBCs rather than relying on self-disclosure. Further study is warranted to evaluate the characteristics of this population.

DUI and underage possession of alcohol were the most commonly reported type of criminal offense, which has special considerations for the nursing profession. The research by Stasiewicz et al. (2007) found that repeat DUI offenders were twice as likely as one-time offenders to suffer from substance use disorders. Those with an active/untreated substance use disorder could pose a threat to patients in the clinical setting. Therefore, an applicant's DUI and other alcohol/drug-related criminal behaviors should be considered when evaluating his or her eligibility to practice.

Limitations

Data collected in retrospective reviews of charts and/or applications depend on the integrity and credibility of the persons collecting and entering the data. In addition, the accuracy of reporting law enforcement agencies contributes to the integrity of the original data. For the purposes of this study, the investigators assumed that data collected by the licensing agency were accurate.

The majority of the cohort that graduated sought initial licensure in Louisiana; however, some participants who graduated from a Louisiana preRN licensure program did not. Finally,

because the majority of this applicant pool was to graduate between 2008 and 2010, the length of practice since graduation may be inadequate to determine if subsequent criminal acts or professional misconduct will occur.

Conclusion

The intent of this study is to prompt nursing educators and regulators to conduct CBCs and consider criminal histories when selecting applicants to ensure that criminal behavior does not pose a risk to public safety or to the character and reputation of the profession. A report by the National Employment Law Project (2011) found that one in four U.S. adults has a criminal record; thus, it is not surprising that 15% of applicants in this study had a criminal history. It is likely that other states have a significant number of applicants with criminal histories.

BONs and schools of nursing may be hesitant to invest time and resources in developing protocols for using criminal histories, but it only takes a few sensational cases to influence the public's trust. In a landmark pilot program in which CBCs were conducted on long-term care workers, only 4.3% were barred from employment for serious crimes. However, because the program screened 220,000 persons, that small percentage equaled 9,509 individuals whose criminal histories posed a significant threat to the vulnerable long-term care population (Majority Staff of the Senate Special Committee on Aging, 2008). According to AACN (2011), 255,671 applications for admission to baccalaureate nursing programs were received nationally between 2010 and 2011. If only 3% had serious criminal histories, that would be more than 7,000 applicants. With the limited number of openings for qualified applicants and the potential for licensure denial for a serious criminal history, BONs should seriously consider the use of CBCs as a criterion for admission to clinical nursing courses.

As more BONs use CBCs as a condition of licensure and more schools require CBCs as a condition of enrollment, it will be increasingly important for them to work together. Establishing standards of fitness for the profession using a CBC before enrollment in the first clinical nursing course, using the latest technologies to improve the efficiencies and effectiveness of CBCs, and conducting and publishing more research to assure the public that public protection is paramount for nursing regulators are a few of the issues that need to be addressed. The agencies entrusted with establishing rules, regulation, policy, and criteria regarding enrollment in clinical nursing courses and nursing licensure have a formidable challenge in balancing public protection and the individual's right to select a career path. Perhaps this study will open the door for additional dialogue and research to assist in this difficult task.

References

American Association of Colleges of Nursing. (2011). Enrollments and graduations in baccalaureate and graduate programs in nursing. Retrieved from http://www.aacn.nche.edu/research-data/standard-data-reports

Berry, L. (2010). Criminal backgrounds. *Nursing Standard, 24*(46), 61.

Clapp, J. D., Johnson, M., Voas, R. B., Lange, J. E., Shillington, A., & Russell, C. (2005). Reducing DUI among U.S. college students: Results of an environmental prevention trial. *Addiction, 100,* 327.

Clevette, A., Erbin-Roesemann, M., & Kelly, C. (2007). Nursing licensure: An examination of the relationship between criminal convictions and disciplinary actions. *Journal of Nursing Law, 11*(1), 5–11.

Criminal History Record Information. (2005). La. Admin Code. 46 LAC XLVII.3331

Farnsworth, J., & Springer, P. (2006). Background checks for nursing schools: What are schools doing? *Nursing Education Perspectives, 27*(3), 148–153.

Jones, M., & Weninger, R. (2007). Student criminal background checks: Considerations for schools of nursing. *Journal of Nursing Law, 11*(3), 163–170.

Kurlychek, M., Brame, R., & Bushway, S. (2006). Scarlet letters and recidivism: Does an old criminal record predict future offending? *Criminology & Public Policy, 5*(3), 483–504.

Louisiana State Board of Nursing. (2011). Annual report. Retrieved from www.lsbn.state.la.us/Portals/1/Documents/AnnualReport/AnnualReport2011.pdf

Majority Staff of the Senate Special Committee on Aging. (2008). Building on success: Lessons learned from the federal background check pilot program for long-term care workers. Retrieved from http://aging.senate.gov/letters/bcreportexecsummary.pdf

Moody, K. (2010). Louisiana's approach to criminal background checks of nursing students. *Journal of Nursing Regulation, 1*(1), 48–51.

National Employment Law Project. (2011). 65 million 'need not apply.' The case for reforming criminal background checks for employment. Retrieved from nelp.3cdn.net/e9231d3aee1d058c9e_55im6wopc.pdf

Smith, M. (2007). Identify your staff with criminal background checks. *Nursing Management, 38*(4), 12–14, 76.

Stasiewicz, P. R., Nochajski, T. H., & Homish, D. L. (2007). Assessment of alcohol use disorders among court-mandated DWI offenders. *Journal of Addictions & Offender Counseling, 27*(2), 102–112.

Surowiec, V. (2010). Does past criminal behavior predict future criminal behavior? *Journal of Nursing Regulation, 1*(3), 33-37.

Zhong, E., Kenward, K., Sheets, V., Doherty, M., & Gross, L. (2009). Probation and recidivism: Remediation among disciplined nurses in six states. *American Journal of Nursing, 109*(3), 48–57.

Danielle Smith, MSN, RN, is Director of Monitoring for the Louisiana State Board of Nursing (LSBN); **Shana Corvers, PhD,** is Executive Director of the Office of Institutional Research and Planning at Baton Rouge Community College; **William J. Wilson, MS,** is a compliance investigator, Applied Sociology for LSBN. At the time of this writing, **Dominique Douglas, MS,** was a research assistant, Applied Sociology for LSBN; and **Cynthia Bienemy, PhD, RN,** is Director of the Louisiana Center for Nursing for LSBN.

WAC 246-11-420

Application of brief adjudicative proceedings.

(1) If an adjudicative proceeding is requested, a brief adjudicative proceeding will be conducted where the matter involves one or more of the following:

(a) A determination whether an applicant for a license meets the minimum criteria for an unrestricted license and the board proposes to deny such a license or to issue a restricted license;

(b) A determination whether a person is in compliance with the terms and conditions of a final order previously issued by the board;

(c) Any approval of a school or curriculum when such approval by the board is required by statute or rule; and

(d) A determination whether a license holder requesting renewal has submitted all required information and meets minimum criteria for renewal.

(2) If an adjudicative proceeding is requested in a matter not listed in subsection (1) of this section, a brief adjudicative proceeding may be conducted in the discretion of the presiding officer when it appears that:

(a) Only legal issues exist; or

(b) Both parties have agreed to a brief proceeding; and

(c) The protection of the public interest does not require that the board provide notice and an opportunity to participate to persons other than the parties.

[Statutory Authority: RCW 18.130.050(1) and 18.130.060(3). 94-04-078, § 246-11-420, filed 1/31/94, effective 3/3/94. Statutory Authority: RCW 18.130.050(1) and 34.05.482. WSR 93-08-003 (Order 347), § 246-11-420, filed 3/24/93, effective 4/24/93.]

Department of Health Health Systems Quality Assurance	1-2-52

Title: Brief Adjudicative Proceedings	Supersedes: HPQA 252

Purpose	This standard business procedure defines the circumstances when Brief Adjudicative Proceedings (BAPs) will be used and how they will be conducted.
RCW, WAC or policy	RCW 34.05.482 – 494; WAC 246-10-501 – 505; WAC 246-11-420 - 450
Tools or Forms:	**Tools:** • Brief Adjudicative Proceedings Flowchart **Forms:** • 1-2-52A - BAP request form [DOH Form No. 600-055] • 1-2-52B – BAP Acknowledgement Letter
Approved by Office Director(s) **Commission(s)** **Chief Administrator** **Date Approved for posting**	Health Professions & Facilities: Steve Saxe Customer Service: Shannon Beigert Investigation and Inspection: Dave Magby Legal Services: Kristi Weeks Community Health Systems: Janet Kastl Nursing Commission: Paula Meyer HSQA Chief Administrator: Sam Marshall March 14, 2010
Effective date:	June 16, 2010
Date for review:	June 16, 2011
Contact person: **Office:** **Phone:**	Debi Young Office of Legal Services 236-4719

A brief adjudicative proceeding (BAP) is an abbreviated hearing process based on review of documents and records. A BAP is used in limited circumstances where witnesses are not necessary.
This standard business procedure defines

- When a BAP will be offered
- How the BAP is established
- How the BAP is managed
- How reviews and appeals of the BAP will be conducted

DEFINITIONS	
BAP presiding officer	The senior staff attorney for secretary authority programs. For boards and commissions, a designee authorized by the disciplining authority to conduct brief adjudicative proceedings.
Initial Order	A Findings of Fact, Conclusions of Law and Order issued by the BAP presiding officer.
Notice of determination	A letter that notifies the recipient of the right to request a BAP because of certain agency actions.

STEPS		
	Activity or Event(s)	**Person(s) Involved**
	For purposes of this standard business procedure, a brief adjudicative proceeding is referred to as a BAP.	
1.	A BAP is available in these circumstances: • Mandatory suspensions for default on a student loan or failure to pay child support. • Mandatory suspension of massage therapist license based on criminal conviction identified in RCW 18.108.085 • Decision not to approve a health professional school or curriculum for failure to meet minimum requirements. NOTE: A BAP is not used when the action is under RCW 18.130.055, which uses the exception application practice.	
2.	Staff begin the BAP process by sending a notice of determination. The notice is mailed the day it is dated. NOTE: Staff attorneys are available to assist with preparing the notice of determination. The notice includes: • Date • Title "Notice of Determination" under the letterhead logo • Clear statement of the program's decision • Summary of the facts on which the decision is based • Statement of the laws and rules upon which the decision is based, including specific citations and the language of the law or rule • Notice of the opportunity to request a BAP within o 20 days of the notice of determination for mandatory suspensions o 30 days of the notice of determination for denial of school or curriculum • Identity and authority of the author • Signature of the author	HPF program

	• BAP request form 1-2-52A	
3.	If the BAP request form is returned before the deadline, staff enter the case in ILRS. If the case involves a profession under a board or commission, staff obtain or confirm delegation to the BAP presiding officer (usually the senior staff attorney) and place the delegation in the file. • Delegation may be case by case or for all BAPs.	HPF program
4.	Staff acknowledge the request for BAP within 10 days of receipt of the request. The acknowledgment letter 1-2-52B includes: • A list of all records in the file, including all internal communications and reports • The name of the BAP presiding officer and the case number • A notice that the BAP presiding officer will set the schedule for the BAP	HPF Program
5.	Immediately after acknowledging the request for BAP, staff deliver the original file to Legal Services. These cases do not go through case management. • If additional documents related to the BAP are received, staff deliver them to Legal Services immediately.	HPF
6.	A. Staff do not discuss the case with the BAP presiding officer. B. Staff provide the original file and one copy of the file to the BAP presiding officer and one copy of the file to the assigned staff attorney, if any. C. Staff provide any information received about the BAP to the BAP presiding officer and any assigned staff attorney within 24 hours.	OLS
7.	The BAP presiding officer manages the case. The BAP presiding officer sends a letter setting the schedule for the case. The BAP presiding officer may: • Extend the schedule for cause • Convert the BAP to a full adjudicative proceeding if the case is not appropriate for resolution by BAP • Request additional information from either party • Hear oral argument from the parties or their representatives If additional information is requested, the assigned staff attorney coordinates the response.	OLS

8.	The BAP presiding officer issues the initial findings of fact, conclusions of law and order within ten days of the deadline for submitting documentation or oral argument, whichever is later. Staff provide the order to ACO, which serves the order.	BAP presiding officer OLS - Administrative
9.	Either party may request review of the initial order. The request must: • Be filed with ACO within 21 days of service of the initial order • State the reason for requesting the review and the remedy requested	OCS - ACO
10.	The disciplining authority may review the initial order without a review request. A. Staff manage this process according to board/commission procedures and within statutory time limits. B. If a board/commission determines review of the initial order is needed, staff notify ACO immediately.	HPF
11.	If a review occurs, the assigned health law judge manages the review process and issues a final order.	Health law judge
12.	The initial order becomes final unless there is a review.	

1-2-52A BAP Request Form

Washington State Department of Health

Commission/Board/Program
P.O. Box_____
Olympia, WA 98504-_____
Telephone: (360)_____
Fax: (360) ___ - ____

For Office Use Only	Application/License #:
	Date Request Received:

FORM NO. 600-055

Request for Brief Adjudicative Proceeding

Please Type or Print Clearly

I. Personal Data

LAST NAME	FIRST NAME	MIDDLE NAME
CURRENT ADDRESS (STREET)(SUITE)		TELEPHONE ( )

CITY	STATE	COUNTY	ZIP	FAX ( )

II. Statement of Intent

Check the box to the left and initial to the right which statement best applies to you.

☐ I DO request a Brief Adjudicative Proceeding (BAP) in this matter, and I request to make a personal appearance before the BAP presiding officer. I may provide additional documents for the BAP presiding officer.	_____ INITIALS
☐ I DO request a Brief Adjudicative Proceeding in this matter; however I do not request to make a personal appearance. I may provide additional documents for the BAP presiding officer.	_____ INITIALS
☐ I DO NOT request a Brief Adjudicative Proceeding.	_____ INITIALS
☐ I WILL be represented by an attorney. Their name and address is:	_____ INITIALS

NAME

ADDRESS

III. Special Note

Failure to return this form by _____ **will constitute a default and the initial determination will stand.**
DATE

III. Signature of Applicant, Credential Holder, or Attorney

_____ _____
DATE SIGNATURE

DOH 600-500 REV 2/01/10

1-2-52B BAP Acknowledgement Letter

Applicant Name
Applicant Address

Re: Request for Brief Adjudicative Proceeding (BAP)
(Describe application/mandatory suspension) Master Case Number: _____

Dear Mr._____:

We have received your request for a brief adjudicative proceeding (BAP) in this case. A presiding officer authorized to conduct such proceedings will conduct the BAP. The presiding officer has agency expertise in the subject matter but has not participated in decisions regarding this case.

The presiding officer will send you a letter setting the schedule for this case. The schedule will allow you to submit additional material for consideration. The presiding officer may allow oral argument but is not required to do so. No witnesses will be allowed to testify, so your materials need to be in writing. The presiding officer will review the record related to this matter before reaching a decision. At this point, the record consists of:

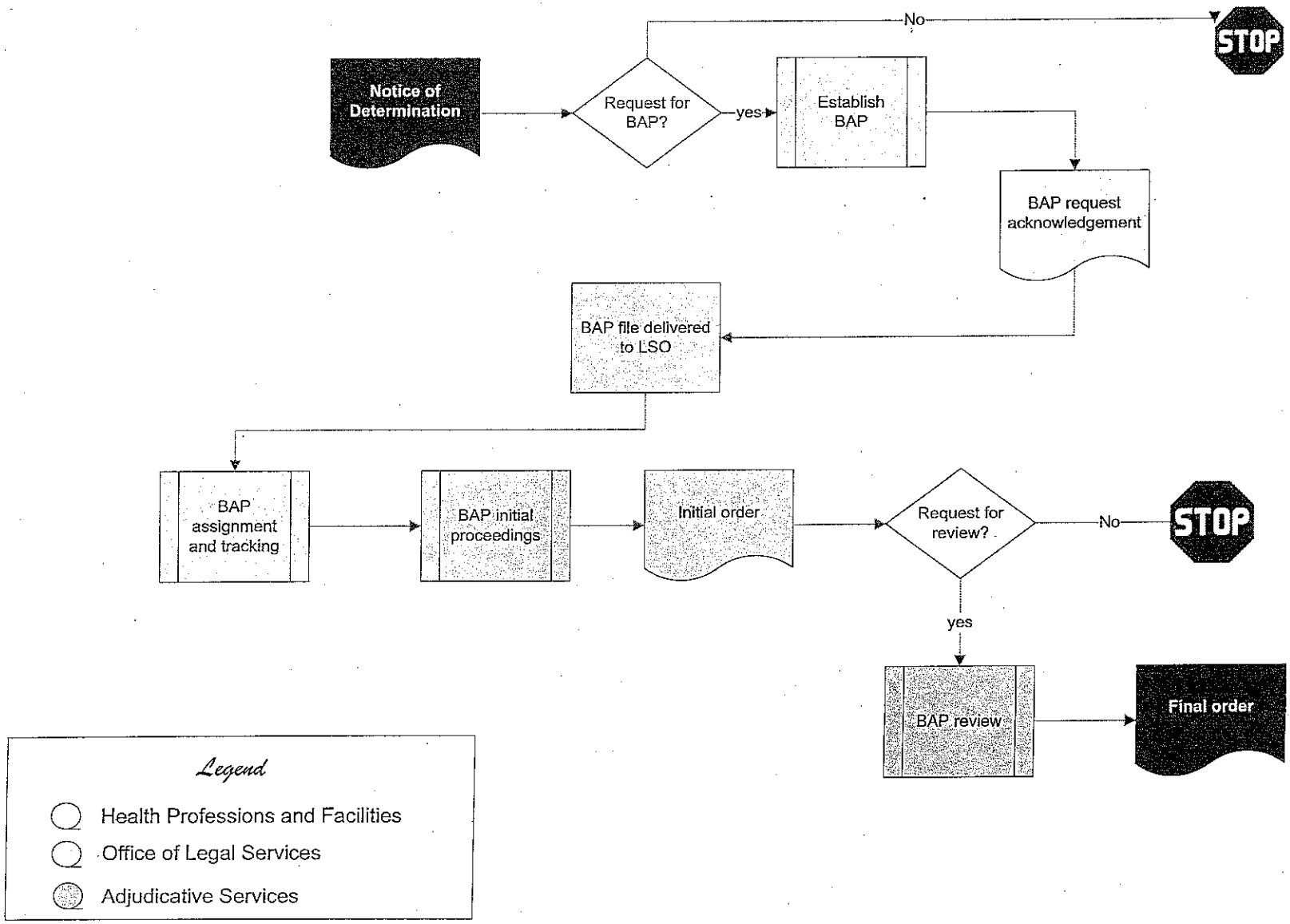
- (list file contents, giving date and number of pages of each item)
- ( )

The presiding officer will issue a written decision. That document will tell you what your options are should you still disagree with the decision.

Sincerely,

DOH staff member

Brief Adjudicative Proceedings
HSQA Practice No. 1-2-52
June 17, 2010



Designation of Presiding Officer
For Brief Adjudicative Proceedings
(RCW 34.05.485 (1)(d))

The Nursing Care Quality Assurance Commission ("Commission") designates initial decision-making authority to either Marc Defreyn, Deputy Director of the Office of Legal Services, or Karl Hoehn, Supervising Staff Attorney, Office of Legal Services, to perform the duties necessary pursuant to the Administrative Procedures Act, Chapter 34.05 RCW and WAC 216-11-430, as Presiding Officer for any Brief Adjudicative Proceedings referred by the Commission.

This designation shall remain in effect as long as Marc Defreyn is the Deputy Director and Karl Hoehn is a Supervising Staff Attorney for the Office of Legal Services, Department of Health, or until earlier revoked or withdrawn by the Commission.

Dated this _____ day of September, 2013.

_____

Suellyn M. Masek, MSN, CNOR
Chairperson
Nursing Care Quality Assurance Commission

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
POLICY

Title:	Lists and Labels Recognition Criteria	**Number:**	A29.03
Reference:	RCW 42.17.260 (9)		
Contact:	Paula Meyer, (360) 236-4713		
Effective Date:	September 13, 2013		
Supersedes:	September 13, 2002; November 16, 2007; July 11, 2008; March 13, 2009; October 19, 2009		
Approved:			
	Chair **Washington State Nursing Care Quality Assurance Commissi**on		

PURPOSE:

Pursuant to RCW 42.56.070(9) staff may give lists of individual nurses, including addresses, to professional associations and educational organizations recognized by the Nursing Care Quality Assurance Commission (NCQAC). An organization or association may be denied recognition by the NCQAC only for good cause after a hearing pursuant the Administrative Procedure Act, RCW 34.05.

PROCEDURE:

This procedure defines criteria for staff to evaluate applications for lists and labels by professional associations and educational organizations. Such associations or organizations meeting these criteria may be given lists of individual nurses, including addresses, upon payment of an appropriate fee as allowed by RCW 42.56.070(9).
If the applicant does not meet these criteria, a hearing before the NCQAC may be scheduled at the request of the organization or association's request.

Educational Organization

An accredited or approved institution or entity preparing professionals for initial licensure in a health care field or providing continuing education for health care professionals.

Professional Association

A group of individuals or entities organized to:

- represent the interest of a profession or professions;
- develop criteria or standards for competent practice; or,

- advance causes seen as important to its members, which will improve quality of care rendered to the public.

Revised: 07/19/11

NAME OF RECOGNIZED ASSOCIATION FOR PURPOSES OF LISTS/LABELS REQUESTS	DATE OF RECOGNITION
1. SEIU (Union)	7/11/08
2. Council of Nurse Educators of Washington State (CNEWS)	9/17/02
3. Washington State Nurses Association (WSNA)	9/17/02
4. Washington Association of Nurse Anesthetists (WANA)	9/17/02
5. School Nurses Association of Washington (SNOW)	9/17/02
6. Association of Operating Room Nurses (AORN)	9/17/02
7. American College of Nurse Midwives	9/17/02
8. Midwives Association of Washington State (MAWS)	9/17/02
9. Washington Association of Perioperative Nurses (WAPN)	9/17/02
10. Washington State Hospital Association (WSHA)	9/17/02
11. Home Care Association of Washington (HCAW)	9/17/02
12. ARNP United	9/17/02
13. Association of Advanced Practice Psychology Nurses (AAPPA)	9/17/02
14. Rural Hospital Associations	9/17/02
15. Washington Hospice and Palliative Care Association	9/17/02
16. All approved schools of nursing as listed in the NCLEX Candidate bulletin for U.S. or U.S. territories jurisdictions	9/17/02
17. King County Nurses Association	8/27/03
18. Western University of Health Sciences, College of Graduate Nursing, 309 East Second Street, Pomona, CA 91766-1854	12/19/03
19. American Red Cross	2/20/04
20. RL University (California)	4/23/04
21. American Academy of Nurse Practitioners, PO Box 12846, Austin, TX 78711 (mjgoolsby@aanp.org)	7/16/04
22. Institute for Natural Resources , 2354 Stanwell Drive, Concord, CA 94250 (925) 609-2820	8/20/04
23. Fred Hutchinson Cancer Research Center	12/2/04
24. National Council of State Boards of Nursing (NCSBN)	3/1/05
25. Old Dominion University	8/15/05
26. Washington Center for Nursing – Seattle – Non profit organization	4/25/06
27. American Nurses Association (ANA)	8/10/06
28. West Sound Advanced Practice Association, 2916 NW Bucklin Hill Road, Suite 232, Silverdale, WA 98383 WSAPA@msn.com	8/10/06
29. Publishing Concepts Inc. (PCI) Virginia Robertson, 14109 Taylor Loop Road, Littlerock, AR 72223 vrobertson@pcipublishing.com	9/20/06
30. University of Phoenix, 3380 146th Place SE, Suite 200, Bellevue, WA 98007 1-800-260-6977 meina.cheng@phoenix.edu	3/12/07
31. Cecil G. Sheps Center for Health Services Research (Branch	7/9/07

of University of North Carolina at Chapel Hill) Alan R. Ellis, MSW, Research Associate and Fellow, 725 MLK Boulevard, CB7590, Chapel Hill, NC27599-7590	
32. Brooks College of Health (ARNP), University of florida, J. Brooks Brown Hall Bldg 39/3031, 4567 St. Johns Bluff Road, South, Jacksonville, FL 32224-2673 (904)-620-2810 Lucy Trice, Ph.D, ARNP, BC	7/18/07
33. Maya Bhat, MPH, Infectious Disease Epidemiologist, Clark County Public Health, PO Box 9825, Vancouver, WA 98666-8825, (360) 397-8000 ext 7257	9/12/07 One time approval
34. Steve Meyer, President, CEO, Fedelta Home Care, Washington Case Manager Association, Home Care & Hospice & National Private Duty Organization, 110 – 110th Avenue NE, Suite 680, Bellevue, WA 98004 (425) 454-4548	9/13/07
35. Gritman Medical Center, Brian Frei, Clinical Educator, Brian.Frei@gritman.org (208) 883-2226	9/20/07
36. Fedelta Home Care, Steve Meyer, 110 110th Avenue NE, Suite 680, Bellevue, WA 98004, (425) 454-4548 or www.fedeltahomecare.com	10/19/07
37. University of Washington Educational Outreach, Amanda Snypp, UWEO Marketing Assistant, 5025 25th Avenue NE, Suite 204, Seattle, WA 98105, (206) 685-6521, asnypp@extn.washington.edu	11/16/07 Full Commission approval
38. Seattle STD/HIV Prevention Training Center University of Washington, 901 Boren Avenue, Suite 1100, Seattle, WA 98104, (206) 685-9846, ammeegan@u.washington.edu	11/16/07 Full Commission approval
39. PESI, LLC, Tommy Bennett, Research and Development, PO Box 1000, Eau Claire, WI 54702, (715) 833-5271 or tbennett@pesi.com	12/7/07
40. National Association of Pediatric Nurse Practitioners (NAPNAP) Nancy Nelson, 3322 Madrona Beach Road NW, Olympia, WA 98502 (360) 866-0854 http://wwww.nurse.org/wa/napnap/	12/13/07
~~41. SEIU Healthcare 775NW, 33615 First Way South, Suite A, Federal Way, WA 98003. Misha Werschkul, (253) 815-3740~~	4/15/08 REMOVED 7/11/08 AT COMMISSION MEETING
42. National Organization of Nurse Practitioners Faculties, Louise Kaplan, Ph.D., ARNP, 14204 NE Salmon Creek Avenue, Vancouver, WA 98686, (360) 546-9618	5/12/08
43. The Research Foundation, 44 Pierrepont Avenue, Potsdam, NY 13676, Laurel Sharmer, Ph.D, MPH, CHES, 315 268-0836	6/26/08
44. Medical Simulation Corporation, Debbie Fimple, 4600 south Ulster Street, Suite 450, Denver, CO 80237 (303) 483-2800	7/08/08
45. Oregon Nurses Association, Mary Schwartz or Kathy Gannett, 18765 SW Boones Ferry Road, Suite 200, Tualatin, OR 97082 (503) 293-0011	07/09/08
46. Washington State Student Nurses	7/11/08 Full Commission approval
47. Cross Country Education, 9020 Overlook Boulevard, Suite 140, Brentwood, TN 37027 1 800- 397-0180 Melissa Harding	8/22/08
48. Medenet, Erich Kaiser 5930 South 58th Street, Suite O, Lincoln, NE	8/22/08

68516 (402) 261-6826 (Educational)	
49. West Sound Advanced Practice Association, Benjamin Miller, 2916 NW Bucklin Hill road #232, Silverdale, WA 98311 (406) 550-9012 (Educational)	9/24/08
50. Research Foundation of the State University of New York, Dr. Laurel Sharmer, 44 Pierrepont Avenue, Potsdam, NY 13676 (315) 268-0836	10/1/08
51. American Red Cross, Mount Rainier Chapter, Walter A. Huber, 1235 south Tacoma Way, Tacoma, WA 98409 (253) 759-2639	1/5/09
52. Health Education Network, LLC, DBA Health Ed. Pat Meixner, 304 Gray Street, Suite 201, Euclaire, WI 54701, (715) 532-9519	1/28/09
53 Tobacco Prevention Resource Center, Deb Drandoff, 2500 NE 65th Avenue, Vancouver, WA 98661 (360) 750-7500 x 303	2/2/09
54. Oregon Health & Science University, Kelsey Cearley, 3181 SW Sam Jackson Park Road, Portland, OR 97239 (503) 494-1475	2/11/09
55. National Association of Nurse Practitioner Faculties, Kitty Werner 9202) 289-8044 or Louise Kaplan (360) 956-1164, 1522 K Street, Washington, DC 20005	2/18/09
56. Eastern Washington University, David Bunting, Ph.D., Department of Economics/PAT300, Cheney, WA 99004 (509) 359-7947	4/22/09
57. Texas Nurses Association, Kristine L. Winning, 7600 Burnet road, Suite 440, Austin, TX 78757, (512) 467-0615 ext 190	6/26/09
58. Pacific Lutheran University, Terry Bennett, 1010 south 122nd Street, Tacoma, WA 98447, (253)-535-7683	7/9/09
59. The Wellness Institute, David Hartman, 3716 274th Avenue SE, Issaquah, WA 98029, (425) 391-9716	10/9/09
60. Legacy Good Samaritan Hospital, Cancer Services, Ileana Craig, 1015 NW 22nd Avenue, Wilcox 106, Portland, OR 97210 (503) 413-7766	10/9/09
61. The Rx Consultant, Tia Daniel, 628 D Street, Martinez, CA 94553	10/9/09
62. SEIU 1199 NW, Diane Sosne, RN, MN, President, 15 South Grady Way, Suite 200, Renton, WA 98057, 1-800-422-8934, fax (425) 917-9707	10/19/09 Added at special commission meeting
63. SEIU 775 NW, David Rolf, President, 33615 First Way South, Suite A, Federal Way, WA 98003, 1-866-371-3200, FAX (253) 815-3701	10/19/09 Added at special commission meeting
64. Transformative Group dba Association for Humanistic Psychology, Susan Burns, MA, LMHC, 2370 130th Avenue NE, Suite 106, Bellevue, WA 98005, (415) 435-1604 or ahpoffice@aol.com	12/3/09 Educational
65. Boise State University, Lori Werth, 1910 University Drive, Boise, ID 83725-1840, (208) 426-4632	12/3/09 Educational
66. Mt. Baker Nurse Practitioner Association, Christine Anderson, 302 36th Street, Bellingham, WA 98225, (360) 815-7043	11/4/09 Association
67. Wu Hsing Tao School, Kristin Bach, 4000NE41 St, Bldg D, Seattle, WA 98105 www.wuhsing.org	12/7/09 Educational
68. Nurse Practitioner Group of Spokane, Marylynn Bernard, 1118 W 28 St, Spokane, WA 99203 509-624-2290	12/7/09 Association
69. Bastyr University, Sue Russell, 14500 Juanita Dr NE, Kenmore, WA 98028 425-787-2697	12/10/09 Educational
70. Seattle University, College of Nursing, Martha H. Goedert, 901 12th Ave Garrant #404, Seattle WA 98122	2/16/10 Educational
71. Western Pain Society, Jennifer M Wagner, 65W-1 Division Ave #237, Eugene OR 97404	5/3/10 Educational

Procedures for List and Label Requests

All requests to be added to the recognized list for purposes of lists/labels requests should be forwarded either to the Executive Director or Deputy Executive Director of Unit #6.

1. All requests for lists and labels should be forwarded to the Manager for the Public Disclosure Resource Center (PDRC).

Adding organizations to the recognized list:

1. The Executive Director or Deputy Executive Director review the request against the Nursing Commission's approved criteria. If the request meets the criteria the name of the organization is added to this list and a copy is sent to the Public Disclosure Resource Center, and the s:drive is updated.

2. If the organization does not meet the criteria the Executive Director or Deputy Executive Director writes a Notice of Intent to Deny to the organization explaining their rights of appeal. A copy of the letter will be sent to the Public Disclosure Resource Center.

3. If the organization files an appeal with the Adjudicative Service Unit a hearing will be arranged with the chair or his or her designee. The hearing will consist of a paper review of the materials supplied by the Department of Health and the appealing organization. A face-to-face hearing is an option for the chair or his or her designee.

DEPARTMENT OF HEALTH HEALTH SYSTEMS QUALITY ASSURANCE	1-4-21

Title: **Lists of Credential Holders**	***Supersedes**:* *HSQA 1-4-21 adopted July 20, 2009*

Purpose	This standard business practice establishes a uniform process to respond to requests for lists of individuals and facilities.
RCW, WAC or policy	RCW 42.56.070, RCW 42.56.350, DOH Policy 17.003
Tools or Forms:	**Tools**: • Lists of Credential Holders Flowchart • List of Approved Entities **Forms**: • 1-4-21A Not Approved Now • 1-4-21B Application for Approval to Receive Lists and Labels • 1-4-21C Request Information – Associations • 1-4-21D Request Information – Ed • 1-4-21E Intent to Deny – Associations • 1-4-21F Intent to Deny – Ed • 1-4-21G Approval – Ed & Associations • 1-4-21H Request for Lists and Labels • 1-4-21I Continuing Approval – Ed & Associations
Approved by Office Director(s) **Pilot Commissions** **Chief Administrator** **Date Approved for posting**	Office of Health Professions & Facilities: Steve Saxe Office of Customer Service: Shannon Beigert Office of Investigation and Inspection: Dave Magby Office of Legal Services: Kristi Weeks Office of Community Health Systems: Janet Kastl Medical Quality Assurance Commission: Maryella Jansen Nursing Care Quality Assurance Commission: Paula Meyer HSQA Chief Administrator: Shannon “Sam” Marshall April 7, 2010
Effective date:	April 8, 2010
Date for review:	April 8, 2011
Contact person: **Office:** **Phone:**	Shellie Carpenter Public Disclosure Unit Manager 360-236-4674

This standard business practice ensures that HSQA responds to requests for lists of persons and facilities in a consistent and informed manner. It ensures that lists are released only to qualified individuals and organizations. It recognizes most requests are public disclosure requests but also that other statutory authority may authorize release of the information.

DEFINITIONS	
Credential holder	A person or facility having a license, certificate or registration issued by a program, board or commission within HSQA.
Commercial purpose	The list will be used to facilitate profit making activity, including recruitment or solicitation.
Disciplinary Authority	The entity authorized by law to regulate the profession.
Educational organization	An accredited or approved institution or entity which: • Prepares professionals for initial licensure in a health care field, or • Provides continuing education for health care professionals.
Professional Association	A group of individuals or entities organized to: • Represent the professional interests of its members; • Develop criteria or standards for competent practice; or • Advance causes that will improve the quality of care rendered to the public.**
Regulatory authority	The entity authorized by law to regulate the profession or facility, including the disciplinary or disciplining authority in the Uniform Disciplinary Act (UDA).
**Note: Boards may adopt a different definition. Staff should use the appropriate definition to implement this procedure.	

STEPS		
	Activity or Event(s)	**Person(s) Involved**
	For purposes of this business practice, reference to the board includes reference to a board or commission.	
1.	Requests for lists of persons or facilities that come from within HSQA are handled by the appropriate program within HPF. • Staff use ILRS to generate the list. • The HPF director or designee coordinates requests involving multiple credential types.	HPF
2.	Requests for lists of persons or facilities that come from outside HSQA are handled by PDRC. HSQA staff send requests to PDRC immediately upon receipt.	HSQA staff
3.	PDRC staff determine how the request should be processed. A. If the request is from a part of DOH outside HSQA,	CSO - PDRC

PDRC staff:

- Check with the HSQA policy director to ensure there are no policy concerns, and
- Fills the request.
- Provides a reminder about any confidential information contained in the list.

NOTE: This is not a public records request.

B. If there is a specific statutory authority or agreement to grant the request, PDRC processes or routes the request as appropriate. If PDRC staff process the request, they:

- Check with the HSQA policy director to ensure there are no policy concerns, and
- Fill the request.
- Provide a reminder about any confidential information contained in the list.

EXAMPLE: Requests covered by an investigation sharing MOU are handled by IIO.

EXAMPLE: Requests covered by the consolidated contracts with local health jurisdictions are processed by PDRC.

C. PDRC treats all other requests as public records requests. The request is acknowledged and processed.

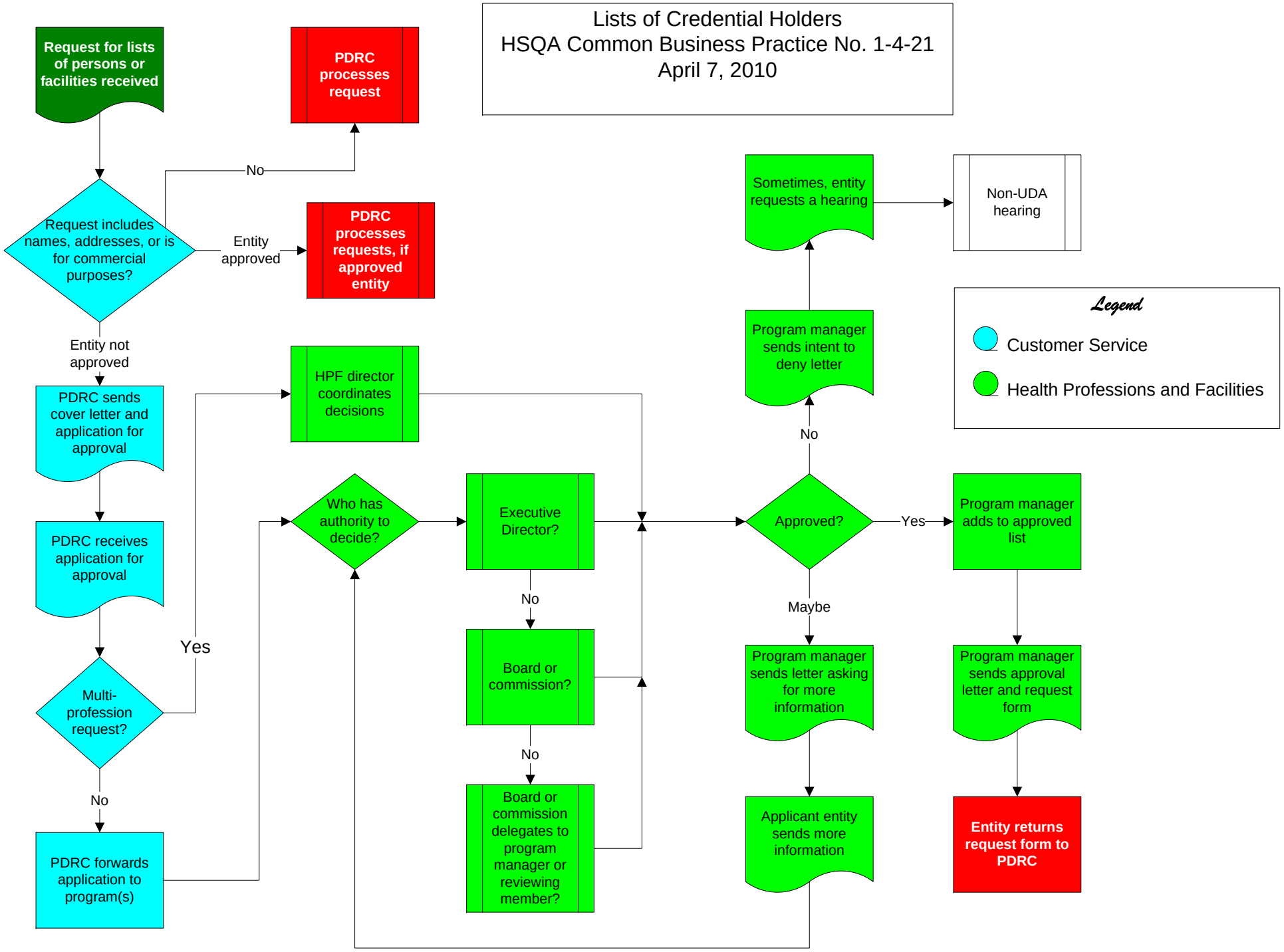
1. If the request is for lists of businesses or facilities, PDRC processes the request.
2. If the request is for lists of names of individuals without addresses or phone numbers, and is not for a commercial purpose, PDRC processes the request.
3. If the request is for names of individuals with addresses, or is for a commercial purpose, and the requestor is an approved entity, PDRC processes the request.
4. If the request is for names of individuals with addresses or phone numbers, or is for a commercial purpose, and the requestor is not an approved entity, PDRC staff send a cover letter

	(1-4-21A) and an application for approval form to the requestor. 5. If the completed application is returned, PDRC staff route the application to the applicable program(s).	
3.	Each disciplinary authority may approve professional associations and educational organizations eligible to receive lists. A. The program manager is responsible for processing the request for approval and maintains the request along with supporting documentation and the approval or denial in program files. B. The appropriate designee makes the decision. When a request involves multiple professions, the HPF director coordinates the decisions. For secretary professions • The executive director or EMS Trauma Manager makes the decision, based on the definitions in this procedure. For board/commission professions: • The board may adopt criteria and delegate the decision to staff, or • A board, subset, or member of the board makes the decision. C. If the decision-maker needs additional information to evaluate the request for approval, program staff send a letter requesting additional information. [1-4-21C Request Info - Association] [1-4-21D Request Info - Ed] D. If the request for approval is granted, approval is given for a period of time not to exceed 5 years. • Program staff send a letter (1-4-21G) along with a request for list/labels form, and • Program staff update the list of approved professional associations and educational organizations. E. If the request for approval does not fall within the definitions of professional association or educational organization, program staff send a letter offering a	HPF CHS NCQAC

	hearing under RCW 42.56.070(9). [1-4-21E Intent to deny – Association] [1-4-21F Intent to deny – Ed]	
4.	Staff maintain a list of approved professional associations and educational organizations for the profession. A. The list of approved professional associations and educational organizations is located on the share drive. B. Program managers update the list whenever approvals or deletions occur. Approval information includes the credential code(s). C. CSO - PDRC reviews the list periodically and sends a reapproval notice and application for approval when an approval is expiring.	CHS HPF NCQAC
5.	A hearing is available if the regulatory authority decides to deny the request for approval. The hearing process is different for secretary professions and for board/commission professions.	
6.	When a hearing is requested for a secretary profession: A. ACO staff notify the program, assign a docket number, and schedule the hearing before a health law judge. Information about the hearing is maintained in ILRS. B. Within three business days of receiving notice from ACO about the request for hearing, program staff prepare, copy and deliver copies of the file to ACO and LSO. The file includes: • The request for approval and any supporting documents • All correspondence with the requesting entity • The intent to deny letter	CSO - ACO CHS HPF
7.	When a hearing is requested for a board or commission profession: A. Program staff schedule the hearing before the board or commission. Information about the hearing is maintained in ILRS.	HPF NCQAC

		B. Within three business days of receiving the request for hearing, staff prepare, copy and deliver copies of the file to ACO and LSO. The file includes: • The request for approval and any supporting documents • All correspondence with the requesting entity • The intent to deny letter	

Lists of Credential Holders
HSQA Common Business Practice No. 1-4-21
April 7, 2010



Professional Association	Approved Profession (use 2-letter abbreviation)	Approval Date	Expiration Date
All approved schools of nursing as listed in the NCLEX candidate bulletin for	RN, LPN, ARNP, Nursing Technicians	9/17/2002	9/16/2007
American Academy of nNurse Practitioners	RN, LPN, ARNP, Nursing Technicians	9/25/2007	9/23/2012
American Academy of Nurse Practitioners	RN, LPN, ARNP, Nursing Technicians	7/16/2005	7/15/2010
American college of Nurse Midwives	RN, LPN, ARNP, Nursing Technicians	9/17/2002	9/16/2007
American Nurses Association (ANA)	RN, LPN, ARNP, Nursing Technicians	8/10/2006	8/9/2011
American Red Cross	RN, LPN, ARNP, Nursing Technicians	2/20/2004	2/18/2009
American Red Cross, Mount Rainier Chapter	RN, LPN, ARNP, Nursing Technicians	1/5/2009	1/4/2014
Anesthetists (WANA)	RN, LPN, ARNP, Nursing Technicians	4/24/2008	4/23/2013
ARNP United	RN, LPN, ARNP, Nursing Technicians	09/17/2002 Reapproved 3/19/09	3/19/2014
Association of Advanced Practice Psychology Nurses (AAPPA)	RN, LPN, ARNP, Nursing Technicians	9/17/2002	9/16/2007
Association of Operating Room Nurses (AORN)	RN, LPN, ARNP, Nursing Technicians	9/17/2002	9/16/2007
Borooks College of health (ARNP)	RN, LPN, ARNP, Nursing Technicians	7/18/2007	7/16/2012
Branch of University of Norht carolina at Chapel Hill	RN, LPN, ARNP, Nursing Technicians	4/24/2008	4/23/2013
Brian Frei, Clinical Educator	RN, LPN, ARNP, Nursing Technicians	4/24/2008	4/23/2013
Cecil G Sheps Center for Health Services Research	RN, LPN, ARNP, Nursing Technicians	7/9/2007	7/7/2012
Council of Nurse Educators of Washington State (CNEWS)	RN, LPN, ARNP, Nursing Technicians	9/17/2002	9/16/2007
Fedelta Home Care Washington Case manager Association, Home Care and	RN, LPN, ARNP, Nursing Technicians	4/24/2008	4/23/2013
Fred Hutchinson Cancer Research Center	RN, LPN, ARNP, Nursing Technicians	12/2/2004	12/1/2009
Gritman Medical Center	RN, LPN, ARNP, Nursing Technicians	9/20/2007	9/18/2012
Harvard School of Public Health	RN, LPN, ARNP, Nursing Technicians	6/23/2010	6/22/2015
Home Care Association of Washington (HCAW)	RN, LPN, ARNP, Nursing Technicians	9/17/2008	9/16/2013
Institute for Natural Resources	RN, LPN, ARNP, Nursing Technicians	7/11/2008	7/10/2013
King County Nurses Association	RN, LPN, ARNP, Nursing Technicians	8/27/2003	8/25/2008
Midwives Association of Washington State (Maws)	RN, LPN, ARNP, Nursing Technicians	9/17/2002	9/16/2007
Mt. Baker Nurses Association	RN, LPN, ARNP, Nursing Technicians	2/12/2009	2/11/2014
Mt. Baker Nurses Association	RN, LPN, ARNP, Nursing Technicians	11/4/2009	11/3/2014
National Association of Nurse Practitioner Faculties	RN, LPN, ARNP, Nursing Technicians	2/18/2009	2/17/2014
National Association of Nurse Practitioner in Women's Health	RN, LPN, ARNP, Nursing Technicians	2/22/2010	2/21/2015
National Association of Pediatric Nurse Practitioners (NAPNAP)	RN, LPN, ARNP, Nursing Technicians	12/13/2007	12/11/2012
National Council of State Boards of Nursing (NCSBN)	RN, LPN, ARNP, Nursing Technicians	3/1/2005	2/28/2010
Nurse Practitioner Alternatives	RN, LPN, ARNP, Nursing Technicians	3/2/2010	3/1/2015

Nurse Practitioner Group of Spokane	RN, LPN, ARNP, Nursing Technicians	12/7/2009	12/6/2014
Old Dominion University	RN, LPN, ARNP, Nursing Technicians	8/15/2005	8/14/2010
Oregon Nurses Association	RN, LPN, ARNP, Nursing Technicians	7/9/2008	7/9/2013
PESI Healthcare	RN, LPN, ARNP, Nursing Technicians	12/7/2007	12/5/2012
Publishing Concepts Inc (PCI)	RN, LPN, ARNP, Nursing Technicians	9/20/2006	9/19/2011
Research Associate and Fellow	RN, LPN, ARNP, Nursing Technicians	4/24/2008	4/23/2013
RL University (California)	RN, LPN, ARNP, Nursing Technicians	4/23/2004	4/22/2009
Rural Hospital Associations	RN, LPN, ARNP, Nursing Technicians	9/17/2002	9/16/2007
School Nurses Association of Washington (SNOW)	RN, LPN, ARNP, Nursing Technicians	9/17/2002	9/16/2007
Seattle STD/HIV Prevention Training Center University of Washington	RN, LPN, ARNP, Nursing Technicians	11/16/2007	11/14/2012
SEIU (Union)	RN, LPN, ARNP, Nursing Technicians	9/17/2002	9/16/2007
SEIU Healthcare 1199 NW	RN, LPN, ARNP, Nursing Technicians	10/10/2009	10/9/2014
SEIU Healthcare 775 NW	RN, LPN, ARNP, Nursing Technicians	10/19/2009	10/18/2014
SEIU Healthcarre 775NW	RN, LPN, ARNP, Nursing Technicians	4/15/2008	4/14/2013
Texas Nurses Association	RN, LPN, ARNP, Nursing Technicians	6/26/2009	6/25/2014
Therapeutic Consultants, Inc	RN, LPN, ARNP, Nursing Technicians	4/20/2010	4/19/2015
University of North Carolina at Chapel Hill	RN, LPN, ARNP, Nursing Technicians	4/19/2010	4/18/2015
University of Phoenix	RN, LPN, ARNP, Nursing Technicians	3/12/2007	3/10/2012
University of Washington Educational Outreach	RN, LPN, ARNP, Nursing Technicians	11/16/2007	11/14/2012
Washington Association of Nurse Anesthetists (WANA)	RN, LPN, ARNP, Nursing Technicians	9/17/2002	9/16/2007
Washington Association of Perioperative Nurses (WAPN)	RN, LPN, ARNP, Nursing Technicians	9/17/2002	9/16/2007
Washington Center for Nursing - Seattle Non Profit Organization	RN, LPN, ARNP, Nursing Technicians	4/25/2006	4/24/2011
Washington Hospice and Palliative Care Association	RN, LPN, ARNP, Nursing Technicians	9/17/2002	9/16/2007
Washington State Hospital Association (WSHA)	RN, LPN, ARNP, Nursing Technicians	9/17/2002	9/16/2007
Washington State Nurses Association (WSNA)	RN, LPN, ARNP, Nursing Technicians	9/17/2002	9/16/2007
West Sound Advanced Practice Association	RN, LPN, ARNP, Nursing Technicians	8/10/2006	8/9/2011
Western University of Health Sciences College of Graduate Nursing	RN, LPN, ARNP, Nursing Technicians	12/19/2003	12/17/2008
Association of Advanced Practice Psychiatric Nurses	RN, LPN, ARNP, Nursing Technicians	8/8/2013	8/7/2018

Educational Oganization	Approved Profession (use 2-letter abbreviation)	Approval Date	Expiration Date
All approved schools of nursing as listed in the NCLEX	RN, LPN, ARNP, Nursing Technicians	9/17/2002	9/16/2007
Bastyr University	RN, LPN, ARNP, Nursing Technicians	12/10/2009	12/9/2014
Boise State University	RN, LPN, ARNP, Nursing Technicians	12/3/2009	12/2/2014
Cross Country Education	RN, LPN, ARNP, Nursing Technicians	8/22/2008	8/21/2013
Eastern Washington University	RN, LPN, ARNP, Nursing Technicians		
Federation of State Medical Boards	RN, LPN, ARNP, Nursing Technicians	2/11/2010	2/10/2015
Foundation for Health & Healing	RN, LPN, ARNP, Nursing Technicians	2/2/2013	2/1/2018
Gerry Grossman Seminars	RN, LPN, ARNP, Nursing Technicians	8/30/2012	8/29/2017
Health Education Network, LLC, DBA Health Ed	RN, LPN, ARNP, Nursing Technicians	1/28/2009	1/27/2014
Implant Seminars	RN, LPN, ARNP, Nursing Technicians	7/6/2010	6/24/2015
Legacy Good Samaritan Hospital, Cancer Services	RN, LPN, ARNP, Nursing Technicians	10/9/2009	10/8/2014
Lewis and Clark Graduate School Of Education and C	RN, LPN, ARNP, Nursing Technicians	7/6/2010	6/24/2015
Medenet	RN, LPN, ARNP, Nursing Technicians	8/22/2008	8/21/2013
Medenet	RN, LPN, ARNP, Nursing Technicians	7/8/2008	7/7/2013
Myotonic Facilitation/Texas Chiropractic College	RN, LPN, ARNP, Nursing Technicians	12/13/2007	12/11/2012
National Association of Pediatric Nurse Practitioners (N	RN, LPN, ARNP, Nursing Technicians	10/12/2009	10/12/2014
Oregon Dental Executive Association	RN, LPN, ARNP, Nursing Technicians	12/12/2013	12/11/2018

Oregon Health & Sciences University -	RN, LPN, ARNP, Nursing Technicians	2/12/2009	2/11/2014
Oregon Hearing Society	RN, LPN, ARNP, Nursing Technicians	7/9/2009	7/8/2014
Pacific Lutheran University School of Nursing	RN, LPN, ARNP, Nursing Technicians	7/7/2008	7/7/2013
Ready Bodies, Learning Minds	RN, LPN, ARNP, Nursing Technicians	8/30/2012	8/29/2017
Seattle University, College of Nursing	RN, LPN, ARNP, Nursing Technicians	2/23/10	11/19/2014
St Martin's University	RN, LPN, ARNP, Nursing Technicians	8/8/2013	8/7/2018
The Institute of Continuing Education	RN, LPN, ARNP, Nursing Technicians		
The Rx Consultant	RN, LPN, ARNP, Nursing Technicians	10/9/2009	10/8/2014
The Wellness Institute	RN, LPN, ARNP, Nursing Technicians	10/9/2009	10/8/2014
Therapy Network	RN, LPN, ARNP, Nursing Technicians	2/2/2009	2/1/2014
Tobacco Prevention Resource Center	RN, LPN, ARNP, Nursing Technicians	12/3/2009	12/2/2014
University of Washington	RN, LPN, ARNP, Nursing Technicians	11/16/2007	11/14/2012
WA State University College of Nursing, Vancouver	RN, LPN, ARNP, Nursing Technicians	2/5/2013	2/4/2018
Washington State Council On Problem Gambling	RN, LPN, ARNP, Nursing Technicians	7/11/2008	7/10/2013
Washington State Student Nurses	RN, LPN, ARNP, Nursing Technicians	9/24/2008	9/23/2013
West Sound Advanced Practice Association	RN, LPN, ARNP, Nursing Technicians	4/13/2009	4/13/2013
Whatcom County Health Department, Whatcom Count	RN, LPN, ARNP, Nursing Technicians		
Wu Hsing Tao School	RN, LPN, ARNP, Nursing Technicians	12/7/2009	12/6/2014
ZL Workshops	RN, LPN, ARNP, Nursing Technicians	8/20/2004	8/19/2009
ZL Workshops	RN, LPN, ARNP, Nursing Technicians	5/3/10	5/2/2015

Educational Oganization	Approved Profession (use 2-letter abbreviation)	Approval Date
All approved schools of nursing as listed in the NCLEX Candidate Bulletin	RN, LPN, ARNP, Nursing Technicians	37516
Bastyr University	RN, LPN, ARNP, Nursing Technicians	December 10 2009
Boise State University	RN, LPN, ARNP, Nursing Technicians	December 3 2009
Cross Country Education	RN, LPN, ARNP, Nursing Technicians	39682
Eastern Washington University	RN, LPN, ARNP, Nursing Technicians	
Health Education Network, LLC, DBA Health Ed	RN, LPN, ARNP, Nursing Technicians	39841
Institute for Natural Resources	RN, LPN, ARNP, Nursing Technicians	38219
Legacy Good Samaritan Hospital, Cancer Services	RN, LPN, ARNP, Nursing Technicians	40095
Medenet	RN, LPN, ARNP, Nursing Technicians	39682
Medical Simulation Corportation	RN, LPN, ARNP, Nursing Technicians	39637
National Association of Pediatric Nurse Practitioners (NAPNAP)	RN, LPN, ARNP, Nursing Technicians	December 13 2007
Oregon Health & Sciences University -	RN, LPN, ARNP, Nursing Technicians	39856
Pacific Lutheran University School of Nursing	RN, LPN, ARNP, Nursing Technicians	40003
Rehab Seminars	RN, LPN, ARNP, Nursing Technicians	Approval Date - 8/30/12
Research Foundation of the State University of New YorkARNP, RN, LP	RN, LPN, ARNP, Nursing Technicians	39722

The Research Foundation	RN, LPN, ARNP, Nursing Technicians	
The RX Consultant	RN, LPN, ARNP, Nursing Technicians	40095
The Wellness Institute	RN, LPN, ARNP, Nursing Technicians	40095
Tobacco Prevention Resource Center	RN, LPN, ARNP, Nursing Technicians	39846
Transformative Groups, dba Association for Humanistic Psychology	RN, LPN, ARNP, Nursing Technicians	December 3 2009
University of Washington - Educational Outreach	RN, LPN, ARNP, Nursing Technicians	November 16 2007
Washington State Student Nurses	RN, LPN, ARNP, Nursing Technicians	39640
West Sound Advanced Practice Association	RN, LPN, ARNP, Nursing Technicians	39715
Wu Hsing Tao School	RN, LPN, ARNP, Nursing Technicians	December 7 2009
Seattle University, College of Nursing	RN, LPN, ARNP, Nursing Technicians	
Rainier Medical Education Program	RN, LPN, ARNP, Nursing Technicians	February 11 2010
Western Pain Society	RN, LPN, ARNP, Nursing Technicians	40301
Institute for Brain Potential	RN, LPN, ARNP, Nursing Technicians	40365
Institute for Brain Potential	RN, LPN, ARNP, Nursing Technicians	40365
Rehab Seminars	RN, LPN, ARNP, Nursing Technicians	Approval Date - 8/30/12
St Martin's University	RN, LPN, ARNP, Nursing Technicians	

WA State University College of Nursing, Vancouver	RN, LPN, ARNP, Nursing Technicians	Approval Date -
Swedish Medical Center: Clinical Education & Practice Department	RN, LPN, ARNP, Nursing Technicians	Approval - 12/12